maryland
health services
cost review commission

594th Meeting of the Health Services Cost Review Commission
April 13, 2022

(The Commission will begin in public session at 11:30 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

EXECUTIVE SESSION
11:30 am

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on March 9, 2022

2. Docket Status – Cases Closed

   Johns Hopkins Hospital - 2582R
   Brook Lane Health Services - 2584N
   Johns Hopkins Medical System - 2586A
   Johns Hopkins Medical System - 2583A
   Johns Hopkins Medical System - 2585A

3. Docket Status – Cases Open

   Tidal Health Peninsula Regional Medical Center - 2587R
   Shady Grove Adventist Medical Center - 2589R
   Johns Hopkins Medical System - 2591A
   Carroll Hospital - 2588R
   Johns Hopkins Medical System - 2590A
   Johns Hopkins Medical System - 2592A

4. Report on Readmissions Reduction Incentive Program (RRIP) for RY 2024

5. Draft Guidelines for Hospital Payment Plans

6. Policy Update and Discussion

   a. Model Monitoring
   b. Legislative Update
   c. Workgroup Update

7. Hearing and Meeting Schedule

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF April 5, 2022

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2587R	Tidal Health Pennisula Regional	2/25/2022	7/25/2022	FULL	JS/AP	OPEN
2588R	Carroll Hospital	3/14/2022	8/11/2022	DEF/MSG	WN	OPEN
2589R	Shady Grove Adventist Medical Center	3/16/2022	8/13/2022	CAPITAL	JS/AP	OPEN
2590A	Johns Hopkins Health System	3/28/2022	N/A	ARM	DNP	OPEN
2591A	Johns Hopkins Health System	3/28/2022	N/A	ARM	DNP	OPEN
2592A	Johns Hopkins Health System	3/30/2022	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

RE: THE FULL RATE	* BEFORE THE HEALTH SERVICES
APPLICATION OF	COST REVIEW COMMISSION
TIDALHEALTH	* DOCKET: 2022
PENINSULA REGIONAL	* FOLIO: 2397
SALISBURY, MARYLAND.	* PROCEEDING: 2587R

* * * * * * * * * * * * *

STAFF RECOMMENDATION

April 13, 2022

List of Abbreviations

APR-DRG	All-Patient Refined Diagnosis-Related Group
CON	Certificate of Need
DRG	Diagnosis-Related Group
ECMAD	Equivalent Case Mix Adjusted Discharge
GBR	Global Budget Revenue
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commissions
ICC	Interhospital Cost Comparison
ICD-10	International Classification of Disease, 10th Edition
JHHS	Johns Hopkins Health System
MHCC	Maryland Health Care Commission
PAU	Potentially Avoidable Utilization
PPC	Potentially Preventable Complication
PSA	Primary Service Area
PSAP	Primary Service Area Plus
PQI	Prevention Quality Indicator
QBR	Quality-Based Reimbursement
SNF	Skilled Nursing Facility
TCOC	Total Cost of Care

Key Methodology Concepts and Definitions

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar clinically and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patient Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 groupings.

Certificate of Need (CON): With certain exceptions, a CON is required to build, develop, or establish a new healthcare facility; move an existing facility to another site; change the bed capacity of a healthcare facility; change the type or scope of any health care service offered by a healthcare facility; or make a healthcare facility capital expenditure that exceeds a threshold established in Maryland statue. The Maryland CON program is intended to ensure that new healthcare facilities and services are developed in Maryland only as needed and that, if determined to be needed, that they are: the most cost-effective approach to meeting identified needs; of high quality; geographically and financially accessible; financially viable; and will not have a significant negative impact on the cost, quality, or viability of other health care facilities and services.

Equivalent Casemix Adjusted Discharges (ECMADS): ECMADS are a hospital volume statistic that account for the relative costliness of different services and treatments, as not all admissions or visits require the same level of care and resources.

Interhospital Cost Comparison (ICC) Standard: Each hospital's ICC revenue base is built up from a peer group standard cost, with adjustments for various social goods (e.g., trauma costs, residency costs, uncompensated care mark-up) and costs beyond a hospital's control (e.g., differential labor market costs) that are not included in the peer group standard. The revenue base calculated through the ICC does not include profits. Average costs are reduced by a productivity factor ranging from 0 percent to 4.5 percent depending on the peer group. The term "Relative efficiency" is the difference between a hospital's actual revenue base and the ICC calculated cost base.

Payer Differential: The HSCRC has employed a differential, whereby public payers (Medicare and Medicaid) pay 7.7 percent (previously 6 percent, prior to July 1, 2019) less than other payers. Commercial payers also pay approximately 2 percent less than billed charges for prompt pay practices.

Potentially Avoidable Utilization (PAU): PAU is the measurement of hospital care that is unplanned and may be prevented through improved care, care coordination, or effective community based care. PAU includes readmissions and hospital admissions for ambulatory-care-sensitive conditions as defined by the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs) measurement approach. PAU may be expressed as a percent of hospital

revenue received from PAU events at that hospital or the rate of PAU events for a hospital's attributed population.

Potentially Preventable Complications (PPCs): 3M originally developed 65 PPC measures, which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. PPCs, like national claims-based hospital-acquired condition measures, rely on present-on-admission codes to identify these post-admission complications. The HSCRC uses a subset of PPCs in its quality pay-for-performance programs.

Primary Service Area (PSA): The Primary Service Area (PSA) was identified by the hospital in their original GBR agreement and is described by a list of zip codes.

Primary Service Area Plus (PSAP): The PSAP is assigned to hospitals based on geography, following the algorithm described below and is modified from the PSA below to allow for attribution of 100% of Maryland residents. This methodology assigns zip codes to hospitals through three steps:

1. Zip codes making up the PSA are assigned to the corresponding hospitals. Costs in zip codes claimed by more than one hospital are allocated according to the hospital's share of ECMADs for inpatient and outpatient discharges among hospitals claiming that zip code. ECMAD, for this purpose, is calculated from Medicare Fee for Service (FFS) claims for the two Federal Fiscal Years 2014 and 2015.

2. Zip codes not claimed by any hospital are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed 30 minutes' drive-time from the hospital's PSA. Plurality is identified by the ECMAD of the hospital's inpatient and outpatient discharges during the attribution period for all beneficiaries in that zip code.

3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

Quality Based Reimbursement (QBR): Maryland's QBR program is similar to the federal Medicare Value-Based Purchasing program and incentivizes quality improvement across a wide variety of quality measurement domains, including person and community engagement, clinical care, and patient safety.

Total Cost of Care (TCOC) Model: The agreement between the State of Maryland and the federal government, which obligates the State to obtain certain levels of health care savings to the federal Medicare program (along with other requirements) through State flexibility provided through the agreement. For example, Medicare participates in the State's system for all-payer hospital global budgets.

Overview

TidalHealth Peninsula Regional Medical Center ("PRMC," or "the Hospital") submitted a full rate application on September 9, 2021, requesting an increase to its permanent Global Budget Revenue (GBR) totaling $56.8 million, an 11.24 percent increase over PRMC's approved GBR that was effective for the one-year period from July 1, 2021 through June 30, 2022. HSCRC staff calculations indicate the request totals to $57.5 million and itemization of this request henceforth will be based off of that value. The requested increase is a general revenue adjustment, with a requested effective date of September 15, 2021. The requested revenue increase is in addition to HSCRC-approved adjustments, including: the update factor, market shift adjustments, demographic adjustments, quality adjustments, population health, and other routine adjustments.

Following the submission of additional required information not included with its original submission, HSCRC staff accepted PRMC's full rate application and considered it complete on March 9, 2022.

Request for General Revenue Increase

PRMC justifies the requested $57.5 million in additional operating revenue based on its objective to increase its profit margin and to make investments in the successful operations of the hospital and delivery of care, most notably as a regional referral center that operates a Level III trauma center under the Maryland Institute of Emergency Medicine Services System (MIEMSS) requirements. The Hospital states that in addition to a revenue enhancement for a 5 percent margin ($23 million), several costs and anticipated outlays contribute to the need for additional revenue[1]:

1. Funding of existing Trauma program expenses --$25.8 million
2. Market adjustment to wages --$16 million
3. Future Medical Education Program (Year 1) --$2.4 million
4. New Adolescent Behavioral Health Program (Year 1) - $3.2 million

[1] Itemized revenue enhancement exceeds total revenue request of $57.5 million because PRMC's initial efficiency evaluation deems the Hospital inefficient relative to the full rate application standard.

Background

Peninsula Regional Medical Center (PRMC)

PRMC is an acute care hospital in Salisbury, Maryland with 266 licensed acute beds that provides the only trauma center coverage on the Eastern Shore, pediatric services, an open heart surgery program that has the seventh highest number of cardiovascular surgeries in the State (301 in Fiscal Year 2019), a labor and delivery program that produces over 1,900 births annually, and an oncology program, among others things. The Hospital's total approved revenue cap for Fiscal Year 2022 was $516,427,928. Approximately 49 percent of its revenues came from Wicomico County residents in 2019, 20 percent came from out-of-state residents (most notably Delaware - 13 percent), 16 percent came from Worcester County, 11 percent came from Somerset County, 2 percent from Dorchester County, and the remaining 2 percent was derived from all other counties in Maryland.[2]

PRMC is part of the TidalHealth Inc., which also includes: TidalHealth Nanticoke, a 139 bed hospital in Seaford, Delaware that was acquired in January 2020; TidalHealth McCready Foundation, an acute facility that was converted to a free-standing medical facility once it merged with Peninsula Regional Health System in March 2020; TidalHealth Medical Partners, a not-for-profit physician network of primary and specialty services that includes physicians from Nanticoke Physicians Network that were acquired in the aforementioned acquisition; TidalHealth Surgery Center, a not-for-profit Ambulatory Surgery Center that provides Women's Health Services in Salisbury, MD; and Peninsula Health Ventures, which is a for-profit organization that includes a home healthcare provider with expertise in Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea (American HomePatient of Delmarva), a full service imaging center (Peninsula Imaging, LLC), and a 50 percent ownership in post-acute facility located two miles from PRMC (Salisbury Rehabilitation and Nursing Center).

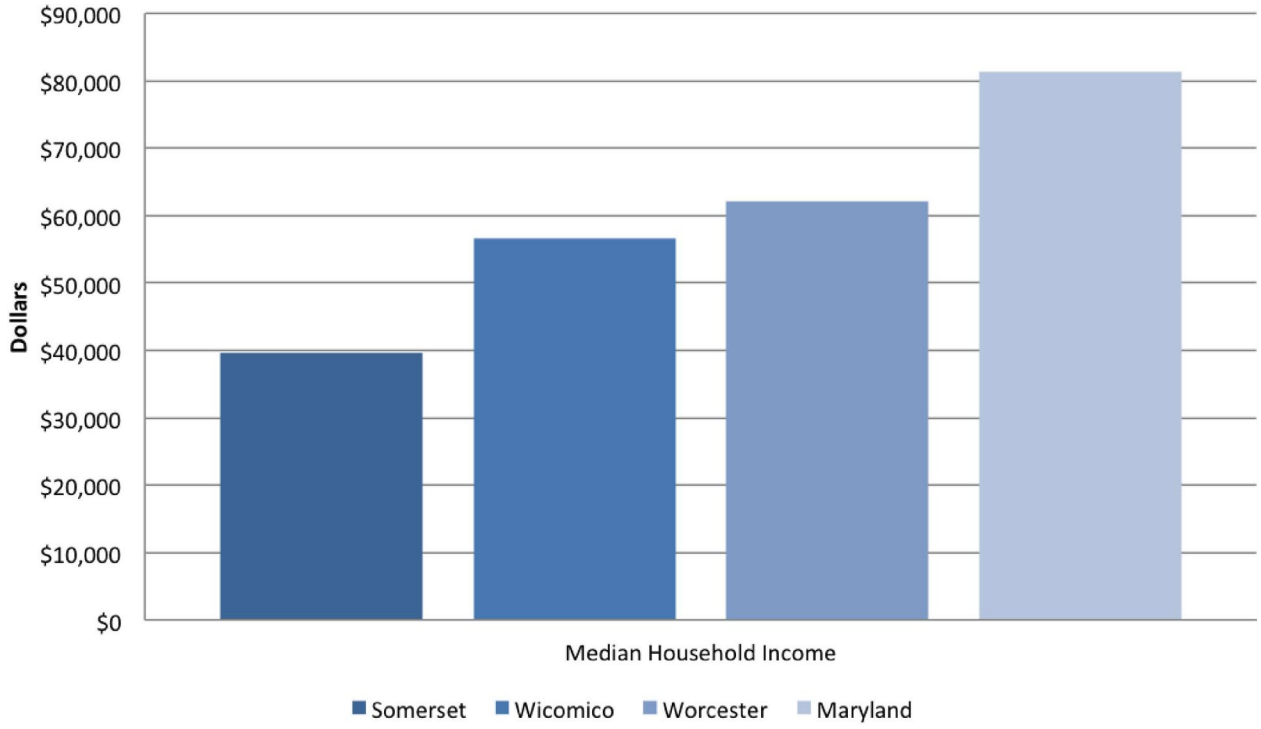
From Fiscal Years 2014 through 2019, PRMC had an average regulated operating margin of 11.0 percent based on its annual filing Schedule RE reporting. Average total operating margin for the same period, inclusive of unregulated losses, most notably physician subsidies, was 0.6 percent. The overall performance for 2014 through 2019 was reduced by regulated margin deterioration in 2017 when operating margin fell to -5.0 percent (5.4 percent regulated). If 2017 is excluded, the average regulated margin for Fiscal Years 2014, 2015, 2016, 2018 and 2019 was 12.1 percent; total operating margin was 1.7 percent. Fiscal Year 2017 similarly affected PRMC's operating cash flow margin, which removes depreciation and amortization and better represents the ongoing cash generation of the organization's operation. From 2014 through 2019, the operating cash flow margin was 6.8 percent, yielding cash generation of $168.1 million; removing 2017, the pro-forma operating cash flow margin would increase to 7.9 percent, yielding a pro-forma cash generation of $195.6 million.

PRMC Service Area and Affordability Implications

The total population estimate for the Tri-County Service Maryland Service Area identified in PRMC's 2019 Community Health Needs Assessment [3] was 180,778. The majority of the population lives in Wicomico County, which had an estimated 103,378 residents. Worcester and Somerset counties had estimated populations of 51,455 and 25,945, respectively.

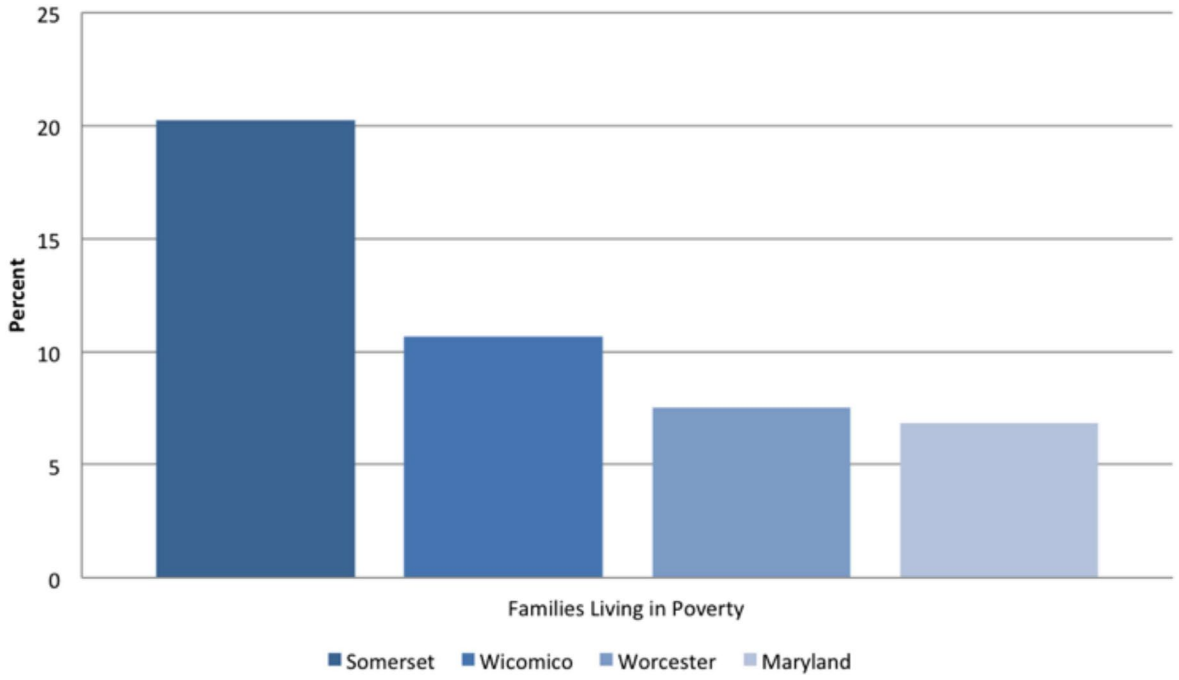
The median household income values in all three counties in the Tri-County Service Area are lower than that of the state of Maryland. In comparison to the state of Maryland overall, all three counties in the Tri-County Service Area have higher percentages of families living in poverty.[4]

Exhibit 1a. Tri-county Service Area Median Household Income



[2] Source: HSCRC hospital discharge data , Fiscal Year 2019
[3] Source: https://www.wicomicohealth.org/wp-content/uploads/2019/06/chna-2019.pdf
[4] Source: IBID

Exhibit 1b. Tri-county Service Families Living Below the Poverty Line



One of the most serious health care problems faced by most Americans is affordability. Increases in hospital charges, such as those requested by PRMC have a direct impact on affordability. As discussed above, income levels in PRMC's service area are lower and poverty levels are higher. In this report, HSCRC staff evaluates the impact of the requested revenue increases on affordability for the residents in PRMC's service area.

Full Rate Applications

In January 2018, the Commission updated its regulations for full rate applications to incorporate new requirements for efficiency. In January of 2021, the Commission, following public comment, approved a policy to evaluate full rate applications. The revised methodology utilizes updated but historical evaluations of hospital cost-per-case efficiency and incorporates new measures of efficiency based on the move from volume-based payments under the charge-per-case system, employed prior to 2014, to a per-capita system with value-based requirements.

Similar to the evaluations of the Garrett Regional Medical Center application in 2018, Suburban Hospital application in 2019, and Bayview Hospital in 2020, HSCRC staff has evaluated the performance of PRMC by reviewing its total cost of care performance, measures of avoidable utilization and quality using the latest data available, and evaluating cost per case under the HSCRC's Interhospital Cost Comparison (ICC) methodology.

As indicated above, HSCRC staff has also evaluated the impact of the requested revenue increases on affordability for the residents in PRMC's service area.

Staff Analyses

HSCRC staff has reviewed costs, financial trends, system financial statements, unregulated losses, volume trends, quality performance, cost-per-case efficiency through the ICC and Medicare and Commercial per capita cost trends in the Hospital's primary service area, among other considerations. Summaries of several of these analyses follow.

Hospital Rate History

PRMC entered into a GBR agreement with the HSCRC for Fiscal Year 2014. Under the GBR agreement, PRMC has received the following adjustments over the subsequent six years:

Exhibit 2. PRMC's GBR Adjustments, RY 2014-2019

Component:	2014	2015	2016	2017	2018	2019
Update Factor	1.65%	2.41%	2.40%	2.64%	2.91%	2.46%
Mark Up Change	0.00%	-0.77%	-0.89%	-0.43%	-0.17%	-0.28%
Demographic Adjustment	0.00%	0.40%	0.18%	0.23%	0.44%	0.52%
Market Shift & other volume adjustments	0.00%	0.00%	-0.01%	-0.60%	-0.12%	0.20%
Net Quality Adjustments	0.00%	-0.08%	0.14%	0.03%	0.33%	-0.60%
PAU	-0.19%	-0.23%	-0.12%	-0.82%	-0.29%	-0.16%
Infrastructure	0.33%	0.33%	0.40%	0.00%	0.00%	0.00%
Oncology Adjustments	0.00%	0.00%	0.00%	0.01%	-0.07%	0.00%
Other	0.00%	0.00%	0.36%	0.00%	0.00%	0.37%
Total	**1.79%**	**2.06%**	**2.46%**	**1.06%**	**3.03%**	**2.51%**

Source: HSCRC final rate files for fiscal years 2014 -2019. Table above shown in percentages.

As reflected in Exhibit 2, annual adjustments to PRMC's GBR averaged 2.15 percent. Excluding one-time adjustments associated with Quality pay-for-performance programs and changes related to markup, annual adjustments averaged 2.61 percent. The mark up reductions resulted from reductions in uncompensated care that occurred primarily as a result of Medicaid expansion under the Affordable Care Act (ACA). As more residents gained healthcare coverage, uncompensated care declined and the HSCRC reduced the amount of uncompensated care from hospitals' rates. Also, the State eliminated an assessment for a high risk individual insurance product referred to as MHIP, over 2014 and 2015, as high risk persons were able to access subsidized coverage through coverage provided under the ACA. These mark up adjustments generally reduce hospital rates, but actual uncompensated care expenses declined at the same time.

Revenue Growth and Financial Condition

PRMC's HSCRC approved regulated revenues have increased by $39.5 million or 9.5 percent since Fiscal Year 2014.

Exhibit 3. Change in PRMC's Approved GBR -For the 5 years Ended June 30, 2019

Year Ended June 30	Approved GBR (in 000's)	Percent Change from Prior Year
2014	$416,053	
2015	$421,601	1.33%
2016	$430,193	2.04%
2017	$437,765	1.76%
2018	$451,199	3.07%
2019	$455,585	0.97%
Change 2014 to 2019	$39,532	9.50%

Source: Peninsula Regional Medical Center Final Rate Order Revenues FY 2014 - FY 2019

As reflected in Exhibit 3, The approved GBR for PRMC grew from $416.1 million in Fiscal Year 2014 to $455.6 million in Fiscal Year 2019, an increase of $39.5 million or 9.5 percent over the span of five years.

According to its annual filings with the HSCRC, PRMC has averaged an operating profit margin of 11 percent or $40.8 million per year on regulated services over the six years ending FY 2019. For all services combined (regulated and unregulated), PRMC has averaged an operating profit margin of 0.6 percent or $2.2 million per year over the six years studied. During this six-year study period, the combined cash flow operating margin, which removes depreciation and amortization and better represents the ongoing cash generation of the organization's operation, averaged $28.0 million per year. In addition to referencing the annual filing, the staff reviewed the audited financial statements for the same six-year period, and noted consistency in the reporting.

Exhibit 4. PRMC Regulated and Unregulated Annual Profit Margins
For the 8 Fiscal Years Ended June 30, 2021

	PRMC Regulated and Unregulated Annual Profit Margins ($ 000's), Under GBRs								PRMC GBR Averages		State wide
Metric	2014	2015	2016	2017	2018	2019	2020	2021	Average 2014 to 2021	Average Excluding 2017	Avg 2014 to 2021
Regulated Operating Margin $	$36,420	$48,495	$38,429	$20,072	$47,317	$53,820	$46,282	$88,631	$47,433	$51,342	
Regulated Operating Margin %	10.4%	13.4%	10.4%	5.4%	12.3%	13.8%	11.5%	19.6%	12.1%	13.1%	8.4%
Unregulated Operating Margin $	($28,729)	($33,051)	($39,247)	($40,578)	($40,419)	($49,078)	($52,699)	($24,852)	($38,582)	($38,296)	
Unregulated Operating Margin %	-107.0%	-104.2%	-107.1%	-99.1%	-79.5%	-74.1%	-65.6%	-70.3%	-88.4%	-86.8%	-43.7%
Total Operating Margin $	$7,691	$15,444	($818)	($20,506)	$6,897	$4,742	($6,417)	$63,779	$8,852	$13,045	
Total Operating Margin %	2.0%	3.9%	-0.2%	-5.0%	1.6%	1.0%	-1.3%	13.1%	1.9%	2.9%	3.0%
Total Cash Flow Operating Margin $	$31,217	$38,802	$21,782	$5,913	$35,840	$34,505	$23,374	$91,143	$35,322	$39,523	
Total Cash Flow Operating Margin %	8.3%	9.9%	5.4%	1.4%	8.3%	7.6%	4.8%	18.7%	8.0%	9.0%	8.5%

Source: PRMC HSCRC Annual Filings - Schedule R

In reviewing Exhibit 4, it is notable that the regulated net operating margin in 2017 is materially lower than that of the other fiscal periods in this comparative study. PRMC management indicated that the hospital installed and began using the EPIC interfacing software for patient electronic medical records during 2017, which resulted in approximately $18.5 million in incremental operating expenses related to the initial EPIC installation and the resulting profit erosion.

The approximate cash on hand at the end of Fiscal Year 2019 was $46.6 million, which was the fourth highest in the State, as measured by system level cash per hospital. When cash and

investments are accounted for, in 2019 TidalHealth the system had $398.6 million, which equated to 338 days cash on hand; this represents the second highest days of cash on hand in the State and well above the statewide average of 192.

Exhibit 5. Cash on Hand For the Fiscal Years Ended June 30, 2019

Rank	System	2019 Cash and Investments (1)	Days Cash On hand (2)
1	Calvert Health System, Inc.	127,015,447	372
2	Tidal Health, Inc.	398,611,000	338
3	Johns Hopkins Health System Corporation	4,364,733,000	247
4	Lifebridge Health, Inc.	984,178,000	245
5	Meritus Medical Center, Inc.	250,752,000	242
6	GBMC healthcare, Inc.	362,182,000	239
7	Holy Cross Health, Inc., Maryland	320,885,000	237
8	Garrett Regional Medical Center	33,801,657	226
9	Anne Arundel Health System, Inc.	416,417,000	211
10	Western Maryland Health System Corporation	174,002,000	209
11	Frederick Regional Health System, Inc.	216,187,000	197
12	Mercy Health Services, Inc.	336,321,000	173
13	Medstar Health, Inc.	2,128,100,000	146
14	University of Maryland Medical System Corporation	1,386,647,000	129
15	Adventist HealthCare, Inc. (1)	238,552,825	114
16	The Union Hospital of Cecil County	47,175,983	114
17	Doctors Community Hospital	57,047,544	90
18	Atlantic General Hospital Corporation	21,089,196	60

.

Looking beyond the six-year period under study, PRMC continues to perform in a positive fashion, notwithstanding the financial effects of the COVID-19 pandemic. The Schedule RE reflects a cumulative operating margin on regulated operations of $134.9 million and a cumulative net cash flow margin on regulated operations of $191.5 million for the two years ended FY 2021. The balance sheet at June 30, 2021 reflects cash and investments, net of advances from third parties of $485.5 million, and the leverage and debt service ratios are very healthy

One potential concern for TidalHealth's financial outlook is its recent acquisitions. Following the acquisition of Nanticoke Memorial Hospital and Nanticoke Physician Network in January 2020, the Peninsula Regional Health System recorded losses from operations for the year ended June 30, 2020 associated with these acquisitions of $2.4 million and $6.2 million, respectively. Following the renaming of these entities in fiscal 2021, TidalHealth Nanticoke Hospital recorded a loss on operations of $11.0 million for the year ended June 30, 2021, and TidalHealth Physician Network recorded a loss of $1.7 million for fiscal 2021 prior to being dissolved into a

newly formed TidalHealth Medical Partners ("Partners"). Partners was constructed by combining the operations of the physicians practices formerly organized under PRMC and under Nanticoke, and which recorded an operating loss of $52.2 million for the stub period ending June 30, 2021. As per reference to a pro-forma presentation prepared by TidalHealth, for the fiscal years ended 2020 and 2021, the combined operating losses of the Medical Partners services are approximately $59.0 million annually of which the former Nanticoke Physicians network accounts for approximately $10.5 million annually. As per reference to a pro-forma budget presentation by TidalHealth, the former Nanticoke Hospital and Nanticoke Physician Network are expected to incur operating losses of $16.5 million and $10.7 million respectively for fiscal 2022. With the acquisition of Nanticoke Hospital and its Physician Network, staff is concerned that PRMC's rate application is in part motivated by the projected ongoing financial deterioration of these entities, totaling $27.2 million initiated through this acquisition. Staff wants to guard against charging Maryland residents and payers for TidalHealth's losses in Delaware.

Staff researched the values of cash and unrestricted investments at June 30, 2021 for the hospital systems in Maryland as per reference to their audited financial statements, so as to gain an understanding of relative available liquid resources, and made note that the state's health systems include those both larger and smaller than TidalHealth. TidalHealth reflects a value of $702.3 million in gross unrestricted liquid resources at June 30, 2021, and $590.5 million net of potential pay backs for advances. The average value of such unrestricted liquid resources available to hospital systems (excluding academic medical centers) in Maryland (exclusive of TidalHealth) as of June 30, 2021 was approximately $629 million gross , and approximately $521 million net of potential paybacks. This comparison implies that TidalHealth has a strong liquid position of available assets on which to draw relative to Maryland's other hospital systems.

Volume Funding

This section of the staff's report addresses historical volumes measured at PRMC.

The HSCRC uses ECMADs to calculate volume changes when possible, because ECMADs include volumes of both inpatient and outpatient services with recognition of expected relative costs of services on a consistent scale. From Calendar Year 2013 through Calendar Year 2019, PRMC has experienced volume declines. Volumes as measured by ECMADs were 36,191 in 2014 and 35,210 in 2019, an implied decrease of 2.7 percent over 5 years. However, this volume growth calculation is not entirely reliable due to the move to ICD-10, which is used for coding diagnoses on hospital bills. The move to ICD-10 made the use of consistent inpatient DRG groupers and weights, for all years, unavailable. Thus, staff have also assessed volume growth through equivalent inpatient days and equivalent inpatient admissions as well as: a) the year over year volume funding relative to funding a 50 percent variable cost factor for growth in in-state

ECMADs; b) the funding of drug costs through the CDS-A methodology; and c) a six year assessment of out-of-state volume funding using billed relative value units.

The volume of patient traffic declined 2.4 percent between 2014 and 2019 as measured by equivalent inpatient days (EIPDs) (127,129 EIPDs in 2014 compared to 124,083 EIPDs in 2019). The approximate average length of stay was fairly stable over the 6-year period of study. This is further supported by analysis of inpatient casemix index (CMI), which measures acuity across all inpatient services, which was relatively stable from 2014 through 2019. Moreover, it appears that the relative acuity of PRMC inpatient services has actually declined slightly, as the CMI was 1.06 and 1.05 in Fiscal Years 2014 and 1.01 and 1.02 in Fiscal Years 2018 and 2019, respectively. An index of 1.0 represents an average index. The reduction in patient volumes and relatively consistent acuity is notable, since regulated employee staffing has remained fairly consistent; regulated FTE's have declined 1.19 percent from 2012 to 2019

Finally, staff also have assembled an analysis that compares expected funding, i.e., growth in in-state ECMADS at a 50 percent variable cost factor, growth in drug costs at average sales price, and out-of-state relative value units at a 50 percent variable cost factor, relative to all volume funding methodologies. Please note there is no underlying population based methodology for out-of-state volume changes, as it is not required under the TCOC contract; staff adjusts global budget revenues when there is material change in out-of-state volumes. Exhibit 6 below summarizes the analyses and shows that PRMC was overfunded for volume changes by $7.4 million annually as of the end of Calendar Year 2019.

Exhibit 6. Volume Funding Provided to PRMC for Six Calendar Years 2014 through 2019 (current dollars, in millions)

	Funding	Expected Funding (50% Variable Cost Factor or Average Sales Price for CDS-A Drugs)	Net Over (Under) Funding
Market Shift (through RY 2021 adjustments)	-$0.2 million		
Demographic Adjustment (through RY 2020 adjustment)	$8.8 million		
Medicaid Expansion	$1.5 million		
Total In-State Volume (excl CDS-A eligible drugs)	$10.1 million	$3.5 million	$6.6 million
Out-of-State Adjustment (excl Drug Rate Center)	$0	$.5 million	-$.5 million
CDS-A Adjustment*	$4.2 million	$2.8 million	$1.3 million
Total Volume**	$14.3 million	$6.9 million	$7.4 million

*The CDS-A assessment does not account for savings related to PRMC converting to a 340b hospital, as all Maryland hospitals have been allowed to retain revenue associated with the conversion. If the savings are accounted for, PRMC has been overfunded for CDS-A drug costs by $10.9 million.

**Volume assessment does not account for inflationary reductions to potentially avoidable utilization, which through Calendar Year 2019, Fiscal Year 2020 amount to $8.4 million, nor does it account for additional revenue provided through infrastructure funding, which in Fiscal Year 2020 dollars amounted to $4.9 million.

Retained Revenue

The most significant incentive for a hospital under the All-Payer and TCOC Model is to reduce avoidable utilization while charging a prospectively determined global budget. To operationalize this incentive, hospitals are allowed to increase charges up to 5 percent over the course of the year as volumes decline by a corresponding amount (10 percent if special permission is granted by HSCRC staff). PRMC has been successful in this endeavor over the course of the Model, especially in recent years.

In Fiscal Year 2019, PRMC increased its charges by 4.2 percent, i.e. volumes were 4.2 percent less than budgeted and the Hospital charged the remaining volume base 4.2 percent more to ensure it collected its entire global budget. This allowed PRMC to retain $18.9 million more in revenue than it otherwise would in a traditional fee-for-service system. The Commission memorialized this additional charging capacity in Fiscal Year 2022 by allowing hospitals to reestablish budgeted volumes equivalent to hospital's experience in calendar year 2019 when it increased charges by 3.2 percent. In effect, PRMC is expected to retain approximately $16.3 million in retained revenue (current year dollars) as long as volumes remain below calendar year

2019 experience. Given the ongoing volume suppression that has occurred due to the COVID-19 pandemic, HSCRC staff believes this retained revenue will be sustained and likely increase.

Affordability

In addition to retained revenue, another central benefit of the State's waiver from Medicare's Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) is that Maryland hospitals do not receive reduced reimbursements from governmental payers. Conversely, private payers, employers, and consumers in other states pay higher hospital rates to cover the losses associated with reduced payment from governmental payers.

In the case of PRMC, which has a disproportionate share of volume attributable to governmental payers (49% is Medicare FFS, 17% is Medicaid, and 4% is Medicare Advantage), this has resulted in more generous reimbursement for PRMC, even after considering potentially higher reimbursement from private payers, employers, and consumers. HSCRC staff have benchmarked payment levels for PRMC versus similar geographic areas for Medicare and private payers. The HSCRC has not benchmarked Medicaid costs but published research shows Medicaid payments range from 70% to 100% of Medicare - for the purpose of this estimate Staff assumed 90%. If all payers are considered, staff estimates the PRMC revenue would be reduced by $15.0 M[5] absent the model:

Medicare reduction:	($57.2)
Medicaid reduction:	($27.4)
Private Payer increases:	$69.6
Total reduction:	($15.0)

HSCRC's full rate application policy (see Full Rate Application Methodology below) calls for a reduction of PRMC's revenue of $10.6 million. So, both under HSCRC's approved Maryland policy and in comparison to similar national geographies PRMC's current reimbursement is generally comparable to a reasonable standard and any increase would make them inefficient versus these standards.

PRMC has requested a regulated revenue increase of $57.5 million (a 11% increase), even though it has consistently generated high profits from regulated hospital operations, has generated an average cash flow margin of $28 million per year,[6] has earned an average of $30 million[7] in investment income over the past 10 years, and has substantial cash reserves relative to other hospitals and health systems in Maryland.

[5] The estimated net loss in revenue to PRMC is estimated based on the level of hospital spending for commercial and Medicare payers in comparable national regions to PRMC's service area as identified in the HSCRC's benchmarking process.

[6] Statistic removes depreciation and amortization and better represents the ongoing cash generation of the organization's operation

[7] Since investments are reported at a system level this reflects results of the applicable system parent for all years.

This calls into question affordability for the residents of PRMC's service area. Increased rates would reduce affordability without efficiency justification. Medicare patients would have to pay for part of these increases through higher co-insurances payments, competing with their ability to pay for housing, food, medications, transportation and other essentials. Likewise, private paying patients and local employers would also have to pay more for services. These higher costs for employers would ultimately be passed on to workers through higher premium contributions, higher co-payments and deductibles. They would also be passed on to workers in the form of lower wage increases, a well-documented fact documented in numerous scholarly articles and studies.[8]

An additional, highly significant threat to local affordability occurs if PRMC's request for additional revenue puts the Maryland waiver at risk by establishing unsustainable statewide precedents. In the event the waiver was lost the PRMC community would lose the additional funding from Medicaid and Medicare noted above, a loss of ~$85 million of external funding. while local business would bear additional costs of ~$70 million. This would be a triple blow to the local residents and businesses resulting in a more financially challenged hospital, significant loss of outside investment and higher local commercial healthcare costs.

Potentially Avoidable Utilization

Staff evaluated the levels of potentially avoidable utilization at PRMC compared to levels of potentially avoidable utilization at all other Maryland hospitals, and PRMC's experience in reducing these volumes. As outlined below, PRMC had lower rates of potentially avoidable utilization relative to the state average. This favorable performance is driven by the Hospital's readmissions, as PRMC has slightly higher avoidable admissions per capita relative to State average but has lower readmissions relative to the state average; it has also reduced readmissions faster than the state average. Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" for which outpatient care can potentially prevent the need to be admitted to the hospital, or for which early intervention can prevent complications or more serious conditions. While PRMC's unfavorable performance in PQI's may be partially attributable to a lower rate of primary care physicians in the Eastern Shore and southern Delaware, as evidenced by Health Professional Shortage Area (HPSA) designations and HPSA scores ranging from 15-19 for PRMC's primary and secondary service areas,[9] it should also be noted that the Hospital's PQI per capita statistics

[8] Increases in health care costs are coming out of workers' pockets one way or another: The tradeoff between employer premium contributions and wages - UC Berkeley Labor Center, Rising health care costs mean lower wages | News | Harvard T.H. Chan School of Public Health

[9] HPSA Primary Care Scores are based on a 25 point scale and include a Population-to-Provider Ratio [10 points max], Percent of population below 100% Federal Poverty Level (FPL) [5 points max],Infant Health Index (based on Infant Mortality Rate (IMR) or Low Birth Weight (LBW) Rate) [5 points max], and Travel time to Nearest Source of Care (NSC) outside the HPSA designation area [5 points max]. https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring

are likely understated because the metric does not account for Maryland residents that seek care outside the State.

Exhibit 7. Potentially Avoidable Utilization Performance

Metric	Hospital Performance	State Quintile	Unweighted State Average
PAU Revenue as a Percent of Eligible Revenue CY19	16.59%	2	17.17%
Readmission Percent Change (CY16-CY19)	-12.32%	2	-4.59%
Readmission Case-Mix Adjusted Rate CY19 w Out-of-State Adj.	10.18%	1	11.22%
PQI rate per 1000 adults for Hospital's Geography	15.61	4	14.45
PQI rate per 1000 adults for Hospital's Geography Percent Change (CY13-CY19)*	-1.1%	3	-0.03%

* The weighted average reduction in PQI's over the course of the All-Payer and TCOC Model (2013-2019) was -13.2 percent.

Quality Performance

Staff reviewed PRMC's performance on Fiscal Year 2021 quality measures for readmissions, potentially preventable complications (PPCs), and the Quality Based Reimbursement (QBR) domains.

Under the HSCRC's Readmissions Reduction Improvement Program (RRIP), PRMC reduced its risk-adjusted readmissions by 12.32 percent between Calendar Year 2016 and Calendar Year 2018, which places PRMC in the 2nd quintile of statewide improvement. When this improvement is compounded with Calendar Year 2013 to Calendar Year 2016 improvement, the total Fiscal Year 2020 improvement is 16.93 percent. Further, PRMC's readmission rate is 10.18 percent, which is in the first or top quintile of statewide performance.

Under the HSCRC's Maryland Hospital Acquired Conditions program, PRMC had a 48 percent improvement in its case-mix adjusted PPCs rate for Fiscal Year 2021, putting it in the 1st quintile of state performance. Furthermore, PRMC's case-mix adjusted PPCs rate for Calendar Year 2019 of 0.97 per one thousand discharges is in the 2nd quintile of statewide performance.

Under the HSCRC's QBR program, PRMC had a Fiscal Year 2021 total QBR score of 24.3 percent, which is in the 5th quintile of statewide performance. Specifically for patient experience, PRMC scored 25 percent, which makes up half of the total QBR score and places them in the 2nd quintile of statewide performance. The Fiscal Year 2021 performance data shows that for the eight HCAHPS measures, PRMC performed better than the national average on 5 measures and improved slightly on all measures except "Discharge Info" and "Care Transitions" measures. On the Mortality measure, PRMC scored 10 percent, which places them in the lowest (5th quintile) of statewide performance. For the safety measures, PRMC scored 16 percent, which also places them in the 5th quintile of statewide performance.

Exhibit 8. Summary of Quality Performance

Quality Program	Metric	Hospital Performance	State Quintile	State Average
MHAC	PPC Percent Change (FY18-CY19)	-48.32%	1	-29.87%
	PPC Case-Mix Adjusted Rate CY19	0.45	5	0.93
RRIP	Readmission Percent Change (CY16-CY19)	-12.32%	2	-4.59%
	Readmission Case-Mix Adjusted Rate CY19 w Out-of-State Adj.	10.18%	1	11.22%
QBR	Patient Experience Domain	25.45%	2	23.00%
	Mortality Domain	10.00%	5	49.07%
	Safety Domain	16.00%	5	38.70%
	Total Score	24.33%	5	33.27%

Full Rate Application Methodology

The Commission approved its full rate application methodology that utilizes the Interhospital Cost Comparison (ICC) and TCOC assessments in January 2021. In the ICC, each hospital's cost-per-case is utilized to develop a peer group adjusted cost-per-case standard, and each hospital's approved ICC revenue is then calculated from the peer group adjusted cost-per-case standard as well as any hospital specific costs that are purposefully passed through without

qualification, e.g., direct and indirect medical education, trauma standby costs. Per Maryland statute, there is no allotment for profit for a non-profit hospital, and, the Commission must assure each purchaser of hospital services that "total costs of all hospital services offered by or through a facility are reasonable; [and] that the aggregate rates of the facility are related reasonably to the aggregate costs of the facility."[10] Furthermore, any costs not evaluated in the ICC due to an insufficient casemix adjustment, most notably oncology drugs, are provided to the hospital without efficiency qualification.[11] The TCOC assessment accounts for both Medicare and Commercial performance relative to national "benchmark" peers as well as TCOC growth relative to Maryland performance; positive or negative performance in TCOC is used to scale the full rate determination made by the ICC.

PRMC's ICC peer group includes all acute care hospitals with the exception of the State's two academic medical centers. The 2020 ICC results show that PRMC's costs per ECMAD were 12 percent lower than the peer group average. However, PRMC had the ninth highest regulated margin in Fiscal Year 2019 among ICC evaluated facilities (13.81 percent vs an average of 9.88 percent),[12] which is the basis for profit removed in the 2020 ICC. Due to the Hospital's above average margin, which means charges that purchasers and consumers pay are well above cost, the 2020 ICC methodology results in a revenue reduction of 3.87 percent. After accounting for the oncology drug costs removed from the ICC evaluation ($14.1 million), total approved revenue for PRMC is $451 million, which is an unfavorable revenue write-down of $17.6 million or -3.75 percent. Finally, because PRMC's 2018 TCOC exceeds that of its benchmark peers (21.47 percent unfavorable; 6th worst in the State) and because PRMC has had TCOC growth in excess of the statewide average (8.48 percent vs 7.31 percent), an additional negative adjustment of $2.2 million is applied to the full rate determination to claw back excess TCOC growth attributable to PRMC. This yields a net unfavorable revenue write-down of $19.8 million or -4.22 percent as described in the "baseline" full rate determination in Exhibit 9. There was no adjustment for Commercial TCOC performance, as the Hospital was 21.99 percent better than its benchmark (21st best in the State), but it cannot obtain a revenue adjustment for this performance due to its Medicare TCOC performance. The calculations performed are in accordance with the central tenet of our statute that charges must reasonably related to costs and the publicly approved policy that governs full rate applications.

[10] Maryland HEALTH-GENERAL Article, An. Code Ann. § 19-219(a)

[11] Statewide there is less than 7 percent of revenue not evaluated by the ICC. PRMC has approximately 5% excluded from the ICC evaluation.

[12] Among the State's seven non-academic trauma centers, PRMC had the second highest regulated margin (13.81 percent vs an average of 9.34 percent).

Exhibit 9. Summary of Components of Baseline ICC and TCOC Recommended Revenue for Peninsula Regional Medical Center*

FRA Methodology	Hospital Revenue Assessed	Revenue Change	FRA Recommend Revenue
ICC Efficiency Tool	$454.5 million	-$17.6 million	$436.9 million
Oncology Drugs	$14.1 million	-$0	$14.1 million
TCOC Assessment	NA	-$2.2 million	-$2.2 million
Total	$468.6 million	-$19.8 million	$448.8 million

***Total may not add due to rounding, Values are Denoted in Fiscal Year 2020 Dollars**

PRMC identified several methodology and revenue enhancement considerations in its rate application that moved the full rate determination from an unfavorable revenue write-down of $19.8 million to a favorable revenue enhancement of $57.5 million. They are as follows:

1) ***Methodology Consideration*** - PRMC noted that the revenue evaluated in the ICC was in excess of the actual revenue provided to the Hospital to support ongoing operations. Staff originally removed $6.7 million from the ICC in recognition of the combined PRMC and McCready Memorial Hospital rate orders, which occurred due to the merger between the two institutions; $6.7 million represents the ongoing revenue that will support operations at the McCready freestanding medical facility. However, PRMC noted that the full amount of revenue attributable to McCready Memorial Hospital should be removed from the ICC, as RY 2019 volumes at PRMC did not yet reflect any transition of services and thus the charge/cost per case was overstated. PRMC's rate application reflects a revenue adjustment to the ICC of $16.7 million, reflecting the revenue that the Commission had approved for McCready Memorial Hospital.

2) ***Methodology Consideration -*** PRMC notes the ICC accounts for the regulated and "...incremental costs associated with the [trauma] program by allowing a "direct strip" of allowed trauma costs. These incremental costs only account for on-call costs and limited administrative costs associated with maintaining trauma program requirements. However, the on-call costs are a relatively small component of the cost of meeting the stringent requirements for maintaining a Level III trauma center in the State. These costs are eclipsed by the need to hire physicians to be available for care, along with the premium required to attract the appropriate professionals to a rural market[13]." In recognition of "...the social costs of meeting the state's requirements for providing Level III Trauma care,"[14] PRMC requests that a direct cost strip of $25.9 million ($25.5 million attributable

[13] PRMC Full Rate Application (Page 51)
[14] IBID (Page 51)

to unregulated physician subsidies and on-call pay) be removed from PRMC's cost per case assessment and then passed through the ICC without qualification. The Hospital also recognizes that a similar cost strip should be provided to the state's other trauma centers, but in the absence of physician contracts for each trauma center, it suggests the cost strip should be equal to the percentage of the PRMC cost strip relative to its total permanent revenue (6 percent).[15]

3) ***Methodology Consideration -*** PRMC suggests that: the benchmarking methodology for Medicare may not be representative of actual TCOC, because it is based on a 5 percent sample of National Medicare beneficiaries; the benchmarking methodology for Commercial has potential data inconsistencies because in the Maryland All Payer Claims Database (APCD) - the source for the Commercial TCOC assessment - CareFirst data are 28 percent lower than reported in the National Association of Insurance Commissioners (NAIC), and there is inconsistent membership identification for United HealthCare; neither the Medicare nor the Commercial benchmarking methodologies directly account for differences in wages levels; and the regression model used for both the Medicare and Commercial TCOC assessments yields higher coefficients for median income than deep poverty, thus "increasing disparities for populations in counties with higher levels of poverty."[16] Due to these concerns, PRMC requests that negative TCOC adjustment be removed from the full rate determination.

4) ***Revenue Enhancement Consideration:*** PRMC requests $3.2 million to fund year 1 expenses for a new psychiatric service line that provides services to children and adolescents. This request is reflective of a 100 percent variable cost factor for an estimated 100 admissions (926 inpatient days) and 2,433 outpatient visits. PRMC further requests that the 100 percent variable cost factor be applied until the program reaches full maturity in Fiscal Year 2025: 373 admissions (3,458 patient days) and 3,650 outpatient visits, which will equate to $9.5 million in additional revenue.[17]

5) ***Revenue Enhancement Consideration:*** PRMC intends to establish a graduate medical education (GME) program and seeks direct and indirect medical education ($244 thousand per resident per year) for 10 residents in year 1 ($2.4 million). PRMC also notes that it anticipates to expand its GME program to a forecasted resident population of 65 over a five year period and would ask that it receive the same direct and indirect medical education credit of $244 thousand per resident per year ($15.9 million) in line

[15] PRMC's Responses to Second Round of Completeness Questions 12.14.21 (Page 9)
[16] PRMC Full Rate Application (Page 59)
[17] Certificate of Need application approved by MHCC on May 16, 2019

with the national Medicare policy on funding new GME programs.[18] The current rate request only reflects the initial 10 residents.

6) ***Revenue Enhancement Consideration:*** PRMC requests $16 million to provide market adjustments to maintain competitive wages.

7) ***Revenue Enhancement Consideration:*** PRMC requests $23 million to generate a 5 percent total operating margin in order to support population health initiatives.

For a complete summary of PRMC's rate application requests see Exhibit 10 below:

Exhibit 10. Summary of Components of ICC and TCOC Proposed Revenue for Peninsula Regional Medical Center Per PRMC Rate Application*

FRA Methodology	Hospital Revenue Assessed	Revenue Change	FRA Recommend Revenue
ICC Efficiency Tool (Reflective of All PRMC Methodology Considerations)	$444.4 million	$12.8 million	$457.2 million
Oncology Drugs	$14.1 million	-$0	$14.1 million
TCOC Assessment	NA	-$0	-$0
Year 1 GME for 10 Residents	NA	$2.5 million	$2.5 million
Year 1 Child & Adolescent Behavioral Health Program	NA	$3.3 million	$3.3 million
Market Adjustment to Wages	NA	$16 million	$16 million
Improved Operating Margin	NA	$23.1million	$23.1million
Total	$458.5 million	$57.5 million	$515.9 million

***Total may not add due to rounding, Values are Denoted in Fiscal Year 2020 Dollars**

[18] Per CMS policy, "if a hospital did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins to participate in training residents in a new medical residency training program (allopathic or osteopathic) on or after January 1, 1995, the hospital's unweighted FTE resident cap (which would otherwise be zero) may be adjusted based on the sum of the product of the highest number of FTE residents in any program year during the fifth year of the first new program's existence at all of the hospitals to which the residents rotate, the minimum accredited length for each type of program, and the ratio of the number FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents in the program that trained at all hospitals over the entire 5-year period" - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10240.pdf

In the following sections, HSCRC staff will respond to all of PRMC's methodology considerations and to two of the four revenue enhancement considerations in greater detail. **The remaining two revenue enhancement considerations ($16 million for competitive wages and $23 million to generate a 5 percent operating margin) are not reasonable requests, as they are not based on an efficiency assessment or an associated methodology consideration, nor do they constitute the establishment of a new, regulated service, which could warrant a revenue enhancement. Moreover, the Commission does not guarantee margins or wage levels and to do so for one hospital on an isolated basis would be inconsistent with general policies. Thus, staff will not dedicate additional research to these topics and recommend rejecting the request for revenue enhancements related to these items.**

Full Rate Application Methodology - McCready Hospital Revenue Adjustment (Methodology Consideration)

HSCRC staff concur with the proposed technical adjustment to increase the McCready Hospital revenue removed from the RY 2020 ICC (currently $6.7 million). Given the merger of the facilities and the combined Fiscal Year 2020 rate orders that prospectively moved revenue from McCready to PRMC in anticipation of inpatient services transitioning to PRMC, it is methodologically unsound to assess this revenue with RY 2019 volumes that had not yet reflected the change in utilization patterns. Staff does not concur, however, that all $16.7 million of McCready's permanent revenue should be removed from the ICC because $4.9 million will be permanently charged at PRMC to support community investments, including capital, and to stabilize McCready's financial performance. These revenues are not associated with volumes that have not yet materialized at PRMC, but rather constitute something akin to the safe harbors in the proposed Revenue for Reform policy, which is not applicable to a full rate application determination. **Thus, staff recommends removing $11.9 million of McCready Memorial Hospital associated revenue from the PRMC Fiscal Year 2020 ICC evaluation. This modification reduces the baseline revenue write-down, as outlined in Exhibit 9, from $19.8 million to $14.7 million.**

Full Rate Application Methodology - Trauma Cost Strip (Methodology Consideration)

HSCRC staff agree that there are inherent, incremental costs to supporting a trauma center. This is why the Commission has historically removed regulated standby costs from the ICC peer group standard. In the case of PRMC, $1.9 million in standby costs is passed through the 2020 ICC without qualification. Additionally, the State has recognized that trauma facilities should be supported for uncompensated care, on-call and standby expenses for physician services, as well as equipment purchases, which is why the Maryland General Assembly in the 2003 legislative session created the Maryland Trauma Physician Services Fund (Trauma Fund). In the case of PRMC, $1.4 million was provided to the Hospital in Fiscal Year 2020 through the Trauma Fund.

PRMC notes that these two supports are insufficient to cover the fixed costs of operating a Level III trauma center. Exhibit 11 below outlines the costs for which PRMC seeks consideration in the ICC:

Exhibit 11. Trauma Fixed Costs

Physician Subsidies and On-Call Pay	$25,473,440	A	Unregulated
Fiscal Year 2020 Trauma Cost per HSCRC Annual Filing Schedule	$1,840,604	B	Regulated
Trauma Fixed Costs	$27,314,044	A+B=C	
Less Trauma Fund	$1,431,736	D	Unregulated
Net Trauma Fund Fixed Costs	**$25,882,302**	E=A-D	
ICC Evaluated Permanent Revenue (Adjusted for McCready)	$435,298,364	F	
% Trauma Strip	6%	G=E/F	

Source: PRMC Responses to Completeness Questions 12.14.21 (Page 9)

PRMC is requesting that $25.8 million ($25.5 million of which is attributable to unregulated physician costs) be stripped out of the ICC evaluation and similarly a 6% cost strip be applied to all trauma centers because the Hospital cannot ascertain the actual trauma fixed costs without access to physician contracts for each trauma facility. HSCRC staff have numerous concerns about the proposed methodology consideration. They are as follows:

1) HSCRC does not have jurisdiction over physician services per statute,[19] and since 93 percent of costs put forward by PRMC as "Trauma Fixed Costs" are unregulated physician subsidies, the proposed cost strip would extend HSCRC's regulatory jurisdiction beyond its statutory authority. The remaining 7 percent of costs put forward by PRMC is already covered by the existing regulated standby cost strip in the ICC.
2) In response to the completeness question: "If these [physician] subsidies will continue in the event that PRMC ceases trauma services, please outline the extent of the subsidies," the Hospital noted the following: "TidalHealth Peninsula Regional has evaluated existing physician subsidies including on-call pay to determine the amount if any that would remain if TidalHealth Peninsula Regional eliminated trauma services. Based on projected volumes and required physician coverage, it is estimated that the $25,473,440

[19] a) In general. – (1) Except for a facility that is operated or is listed and certified by the First Church of Christ Scientist, Boston, Massachusetts, the Commission has jurisdiction over hospital services offered by or through all facilities. (2) The jurisdiction of the Commission over any identified physician service shall terminate for a facility on the request of the facility. (3) The rate approved for an identified physician service may not exceed the rate on June 30, 1985, adjusted by an appropriate index of inflation. Md. HEALTH-GENERAL Code Ann. § 19-211

in physician costs would be reduced to $8,424,224." In effect, PRMC is noting that approximately one third of the proposed cost strip that is needed to support trauma fixed costs would continue if trauma services were discontinued, and thus the proposed cost strip, if allowed, would need to be reduced to $17,458,078 or 4 percent of revenue.

3) The Commission is unable to determine if the subsidies provided to trauma physicians are reasonable, nor does it know whether the assumption that all other trauma facilities have a similar level of costs for trauma coverage is sound; therefore, the Commission would have no basis on which to adjust other Trauma centers should such an allowance be made for PRMC. PRMC has not provided sufficient evidence to assuage these concerns.
4) During the course of the development of the full rate application policy, staff demonstrated that there was no statistically significant relationship between various hospital characteristics and ICC performance. In effect, there were no variables, such as number of medical residents, that had an alarming explanatory power on the outcome of a hospital's ICC assessment. One particular characteristic that was assessed was the presence of a trauma program, both as a categorical and continuous variable, and in both instances there was not a statistically significant relationship, indicating that the Commission's assessment of a hospital's performance under the ICC is not negatively affected by having a trauma program.
5) Unregulated costs are purposefully not reflected in HSCRC efficiency methodologies, and the consideration to include one particular type of unregulated cost due to the argument that it is a social good fails to recognize that similar arguments could be made for other service lines, e.g., labor and delivery, open heart surgery, pediatric oncology, etc. Thus, unless all unregulated costs deemed a social good are allowed in an HSCRC efficiency methodology, contingent on expanded regulatory authority, the handpicking of a select few would disadvantage all other hospitals with a different service array.

In light of these concerns, HSCRC staff do not recommend approving the trauma methodology consideration put forward by PRMC.

Full Rate Application Methodology - Precision of TCOC Benchmarking (Methodology Consideration)

The Commission approved the use of TCOC assessments in its full rate application methodology in January 2020, because historical evaluations based solely on hospital cost per case efficiency do not align with the aims of the TCOC Model.

HSCRC staff understand stakeholder concerns about the precision of the TCOC benchmarking, but staff would note that benchmarking is a complex but necessary process with many reasonable options on how to proceed. From these options, HSCRC staff must select the one they regard as best, balancing competing considerations in an unbiased and justifiable way. Moreover, any perceived imprecision in the underlying benchmarking methodology can be addressed by careful

application of the benchmarking results in HSCRC policies, which is why staff have created a two step algorithm for receiving a TCOC penalty in a full rate application determination. Namely, in order for a hospital to be penalized, it must first be determined to be higher cost than its TCOC benchmark, and it must be growing faster than the statewide average. In the case of PRMC, the Hospital's attributed Medicare population under the existing benchmarking methodology is 21.47 percent more expensive than its benchmark (6th worst in the State), and it has grown 1.17 percent faster than the statewide average.

PRMC has agreed that the growth statistic is not inaccurate but noted that given its concerns with the benchmarking methodology, "...it is unclear whether the rest of the [TCOC] algorithm would remain as currently constructed."[20] HSCRC staff believe this theory is begging the question and thus continue to support the two step TCOC algorithm. In terms of the specific benchmarking concerns put forward by PRMC, staff would note the following:

1) Medicare Data Completeness - The 5 percent sample of Medicare claims is provided by Medicare for research purposes within the Chronic Conditions Warehouse (CCW), which is the same environment and data standard under which Maryland's performance under the TCOC model is evaluated. Therefore, by using the 5 percent data for the nation, HSCRC staff are using a data set that is comparable to the data used in Maryland's performance assessment. The 5 percent sample is widely used by researchers and, more importantly, by qualified entities to develop national benchmarks, indicating staff's use of the 5 percent sample is appropriate (see https://www.qemedicaredata.org/apex/Data_Availability_and_Cost).
2) Commercial Data Validity - The benchmarking relies on Maryland's Medical Claims Database (MCDB, often referred to as APCD), which is compiled by the Maryland Health Care Commission based on data from insurers in the State and national commercial claims data acquired from a highly experienced national vendor (Abt, Inc., and its subcontractor Milliman using Milliman's Consolidated Health Cost Guidelines Sources Database). Moreover, Milliman compared the MCDB data to the Maryland data from their national data set (which undergoes substantial vetting) and determined that data were comparable. Staff also notes that the commercial TCOC assessment is not germane to the PRMC rate application, as it has no scaling effect on the Hospital's full rate determination.
3) Absence of a Wage Adjustment - In lieu of a wage adjustment, staff elected to utilize median income, because a hospital wage index adjustment is circular: only hospital wages in a market are considered in the wage index, which then feeds back into hospitals' ability to pay those wages. The circularity is particularly acute in Maryland, where the TCOC Model has undoubtedly affected the wages paid by Maryland hospitals. There is also widespread concern about the Centers for Medicare & Medicaid Services' (CMS's) wage index that was recommended by PRMC. The Institute of Medicine's report summarized the issues as problems with inconsistencies in the definitions of payment areas and labor markets, concerns about the relevance and accuracy of the source data

[20] PRMC Responses to Completeness Questions 9.23.21 (Page 8)

used to determine area wages and other input prices, questions about the occupational mix used to create the hospital wage and physician practice expense adjustments, and lack of transparency in the index construction. Finally, HSCRC staff also believe that median income and wage factors are collinear, and that one cannot be wholly inappropriate but the other wholly appropriate. In testing, HSCRC staff found that substituting broader wage indices (to avoid the circularity of hospital wage indices) for Median Income did not significantly alter the benchmarking results.

4) Regression Coefficients are more Significant for Median Income than Deep Poverty - HSCRC staff believe this argument overlooks the fact that the regression is the second step in a two-step TCOC benchmarking process. The first step is selecting peer jurisdictions that are similar to the Maryland jurisdictions. The selected peer counties are, therefore, already comparable to the Maryland counties, and the second regression step then adjusts for any *remaining* differences. Thus, any perceived differences in scale are actually due to the initial peer group selection, not an underlying flaw in the selected independent variables in the regression that may lead to inequitable treatment of hospitals and their surrounding service areas.

Finally, in an effort to be responsive to industry concerns on the benchmarking methodology, HSCRC staff worked with its contractor to develop an approach to look at variation in TCOC outcomes across 20 different iterations of the benchmarking analysis. Specifically, the different models used alternative metric sets for peer selection and regression, including three different wage measures to both replace and supplement median income. The alternatives all yielded very similar results to the selected approach, especially in terms of rankings.[21] Moreover, in no model did PRMC's attributed TCOC perform better than its benchmark peers, suggesting that in all cases the Hospital would incur a TCOC penalty under the TCOC algorithm that first tests if a hospital is worse than its benchmark before clawing back excess growth.[22] **Thus, staff does not recommend approving PRMC's request to not consider its TCOC performance under the existing TCOC algorithm.**

Full Rate Application Methodology - Adolescent Behavioral Health Program (Revenue Enhancement Consideration)

Staff is supportive of the request to provide additional funding for child and adolescent psychiatric services in Salisbury, MD, as there are no pediatric inpatient services available on the Eastern Shore. Moreover, this request was approved by MHCC through the CON process in

[21] The lowest Spearman correlation between the rankings under the selected approach and the rankings among the 20 alternatives was 0.87, yielding an average absolute change in rank of 2.8 (which was driven by variations in the smallest counties). The Spearman correlation for most alternatives was well over 0.90. In addition, staff did not find any biases against types of counties (such as rural counties or counties in the Baltimore area) when using the selected approach versus the alternative approaches.

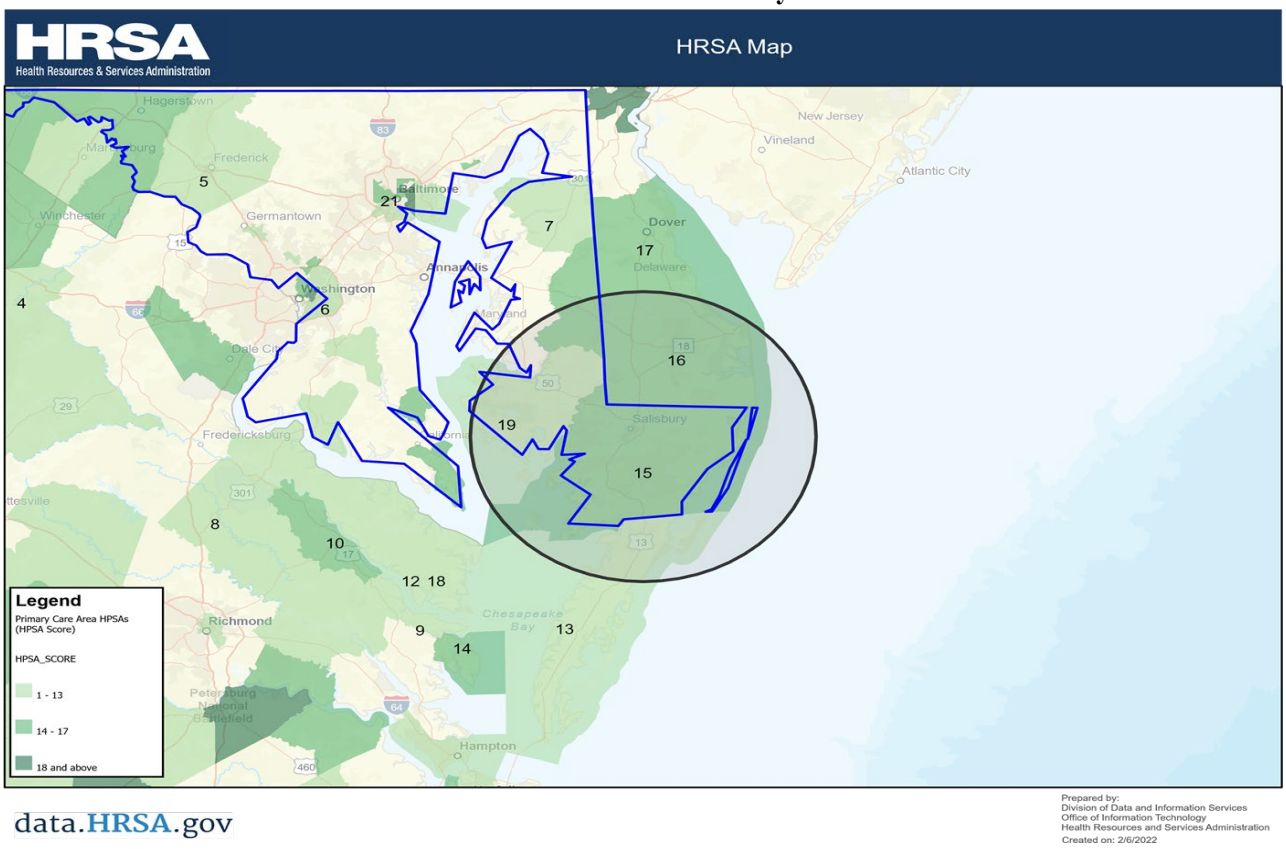
[22] For more information on the HSCRC's validation of its benchmarking methodology, please see: https://hscrc.maryland.gov/Documents/Memo%20on%20Additional%20Benchmarking%20Considerations-2-4-22%20FINAL.pdf

May 2019.[23] Staff would note, however, that in keeping with prior volume policies for new regulated services (e.g., open heart surgery program at Anne Arundel Medical Center), the funding should be limited to a 50 percent variable cost factor. **Thus, staff recommends reducing PRMC's request from $3,249,853 to $1,624,927. The 50 percent variable cost factor will be applied to growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025. All prospective adjustments for volume will be subject to retrospective review and settlement, including an accounting of volume funding received from the market shift methodology. In tandem with the McCready methodology consideration, this modification reduces the baseline revenue write down, as outlined in Exhibit 12, from $19.8 million to $13 million.**

Full Rate Application Methodology - Graduate Medical Education Program (Revenue Enhancement Consideration)

PRMC provides the vast majority of its services in a portion of the State that is considered a primary care health professional shortage area (HPSA), and its out-of-state volume is similarly from a designated HPSA.

Exhibit 12: PRMC Service Area and Primary Care HPSA Scores



[23] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2019_decisions/con_peninsula_2417_decision_20190516.pdf

Thus, a priori, it is logical that PRMC would start a residency program to increase its physician supply, especially for primary care physicians (PCP). The specialty mix for the intended residency program, however, is not exclusive to PCP's, as evidenced by Exhibit 13 below, which shows the projected resident count through the first five years of the program and will serve, per PRMC, as the basis for the resident cap in future ICC analyses:

Exhibit 13: Specialty Mix for Intended Residency Program

Specialty	Academic Year 2022 -2023	Academic Year 2023 -2024	Academic Year 2024 - 2025	Academic Year 2025 - 2026	Academic Year 2026 - 2027
Internal Medicine	10	20	30	30	30
General Surgery		3	6	9	12
OBGYN			4	8	12
Psychiatry				4	8
Anesthesiology					3
Total	10	23	40	51	65

Source: PRMC Full Rate Application (Page 56)

Because the specialties identified by PRMC are not exclusive to primary care, HSCRC staff utilized a physician supply analysis that it contracted with Mathematica Policy Research (MPR) to author. The study uses groupings based on literature (Grasreiner 2018, Weiss 2017) that consolidate over 60 medical specialties (and 100 subspecialities) into five medical specialty groups. Following this consolidation, the study then assessed the physician supply of each consolidated specialty by metropolitan statistical area (MSA) in the State versus 20 comparable regions outside of Maryland, as derived from the TCOC benchmarking assessment. The results of that assessment are identified in Exhibit 14 below.

Exhibit 14:Eastern Shore MSA Physicians Per Capita Relative to National Peers

	Total	Primary medical	Nonprimary medical	Surgical	Diagnostic	Psychiatric
Eastern Shore						
Number	880	382	213	173	43	69
Rate per 100,000	148	64	36	29	7	12
Peer MSA ranking	12	11	12	14	14	7

Source: National Plan and Provider Enumeration System, November 2020; U.S. Census, June 2019.; Note: Each region has a total of 20 peer MSAs and the populations of these MSA's are adjusted for differences in health status based on average Medicare HCC scores and HHS platinum risk scores at the MSA level. MSA rankings indicate that region's physician density relative to its 20 peer MSAs; 1 indicates the MSA has the highest density and 21 indicates that the MSA has the lowest density. HCC and HHS platinum risk scores were calculated in the HSCRCs benchmarking process and can be found in the benchmarking materials available on this page: https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx

The Eastern Shore, across all consolidated specialties, does not appear to have a high number of physicians per capita relative to national peers, as in only one case does the Eastern Shore exceed the median of its peers for physician supply (psychiatric physicians ranks 7th). Additional analyses in the study that account for physician productivity and age, among other things, also indicate that the supply in the Eastern Shore is potentially inadequate to address the current level of visits provided in the region, both in the near term and the long term. Thus, HSCRC staff believe that addressing physician supply in the Eastern Shore is important to maintaining access in the region. However, HSCRC staff contend that doing so with a residency program is potentially an inefficient approach that utilizes scarce resources in a fixed revenue system, i.e., the TCOC Model, and GME in Maryland is already heavily invested relative to the rest of the nation.

Staff note that GME is potentially an inefficient approach to addressing physician supply, because residents that complete training do not necessarily stay in the area. AAMC's 2019 State Physician Workforce Data Report notes that only 37 percent of physicians that completed GME in Maryland stayed in Maryland.[24] Moreover, staff's own analysis yields an even lower

[24] https://store.aamc.org/downloadable/download/sample/sample_id/305/ (page 78)

retention rate of 11.9 percent. Staff used data from the Healthcare Cost Reporting Information System (HCRIS) and the Maryland Board of Physicians to assess patterns of medical resident retention in Maryland and across regions within the State. Staff first used the HCRIS data to calculate the average annual number of medical residents who graduated from each of the 19 teaching hospitals in Maryland from 2016 through 2018. Staff then used information from the state's licensure data on where recent medical graduates in Maryland were trained, and where they established their primary medical practice after graduation to determine the number of medical graduates who stay and practice medicine in Maryland each year, and in which regions of the State they practice. Exhibit 15 below shows the findings of this analysis:

Exhibit 15: Average annual number and rate of newly graduating physicians entering workforce in Maryland, by region and specialty

Hospital	MSA cohort	Average number of medical residents in Maryland	Number of residents graduating in Maryland each year	Number of graduating residents practicing in Maryland	In-state retention rate (%)
The Johns Hopkins Hospital	Baltimore Area	911	228	27.7	12.2
University of Maryland Medical System	Baltimore Area	622	155	24.7	15.9
Johns Hopkins Bayview Medical Center	Baltimore Area	164	41	1.7	4.1
Sinai Hospital of Baltimore	Baltimore Area	133	33	2.7	8.0
Medstar Union Memorial Hospital	Baltimore Area	89	22	3.0	13.4
St. Agnes Hospital	Baltimore Area	73	18	1.0	5.5
Medstar Franklin Square Medical Center	Baltimore Area	69	17	2.7	15.4
Greater Baltimore Medical Center	Baltimore Area	58	14	1.7	11.6
Mercy Medical Center	Baltimore Area	50	13	1.3	10.6

UM Prince Georges Hospital Center	Southern Maryland	47	12	1.3	11.3
Maryland General Hospital	Baltimore Area	46	12	0.0	0.0
Medstar Harbor Hospital	Baltimore Area	41	10	1.7	16.4
Good Samaritan Hospital	Baltimore Area	37	9	1.0	10.8
Holy Cross Hospital	Northern DC Suburbs	24	6	0.0	0.0
Kennedy Krieger	Baltimore Area	21	5	1.0	19.2
Sheppard & Enoch Pratt Hospital	Baltimore Area	20	5	1.0	20.1
James Lawrence Kernan Hospital	Baltimore Area	7	2	0.0	0.0
Suburban Hospital	Northern DC Suburbs	6	2	0	0.0
Anne Arundel Medical Center	Eastern Shore	6	2	0	0.0
Total		**2,425**	**606**	**72**	**11.9**

Source: Hospital Cost Reporting Information System, 2016–2018, Maryland Board of Physicians data, accessed in November 2020.

Note: The number of graduated residents practicing in Maryland was defined as the number of physicians who were licensed as of the November 2020 Maryland Board of Physicians roster file who reported graduating from a medical residency program in Maryland from 2015 through 2017. If physicians completed more than one residency, internship, or fellowship, they were counted as Maryland-trained if any of these trainings were in a Maryland-based program.

In response to these statistics, PRMC noted that "...the long-term trends in the retention of graduates appears to be larger than the numbers in recent years. According to the AAMC, Maryland retention rates from 2008-2017 averaged 47.3 percent -- still lower than the nation but substantially higher than the recent-year averages."[25]

[25] PRMC Responses to Completeness Question (Page 12)

While there is merit to PRMC's argument, any policy that aims to address physician supply, especially in a fixed revenue system, should be weighed against other options, most notably loan assistance repayment programs. Staff could not assess the efficacy of the Maryland loan assistance repayment program because the State does not track retention at this time, but staff did find in a 2019 Delaware Health Care Workforce Study that from 2012 to 2019, Delaware made 59 loan repayment awards, of which 34 were provided to physicians, for a total of $2,529,000 ($57 thousand per provider), and 40 of the 43 providers are still working in Delaware, which is a retention rate of 93 percent.[26] Given the performance of the Delaware loan assistance repayment programs and the fact that the retention rate of the state's GME programs ranges from 11.9 percent to 47.3 percent at a cost of $244 thousand per resident (per PRMC's filing), there is a question of whether or not residency programs are the most efficient way to address physician supply.

Finally, staff notes that Maryland has already invested significantly in GME. Based on staff analyses (see exhibit 16 below), Maryland's GME spending per Medicare and Medicare Advantage beneficiary is $35.9 million more than the national experience. Moreover, for the nation to have a similar level of investment in GME, it would need to add 13,508 residents at its current rate of funding for direct and indirect medical education. While Congress is considering a proposal that would provide 14,000 GME slots over seven years,[27] approved legislation in 2020 only approved 1,000 slots over 5 years.[28] **Given Maryland's existing level of GME funding relative to the nation and the State's required savings per the TCOC contract, HSCRC staff recommend Commissioners consider a standard by which additional GME slots could be funded in the State. Specifically, until national funding of GME per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland, no additional funding for new GME slots, including PRMC's request, should be provided in hospital rates.**

[26] https://dhss.delaware.gov/dhss/dhcc/files/hlthcrewrkfrcestudy2019.pdf

[27] https://www.aamc.org/advocacy-policy/washington-highlights/bill-expand-graduate-medical-education-introduced

[28] https://www.cms.gov/newsroom/press-releases/cms-funding-1000-new-residency-slots-hospitals-serving-rural-underserved-communities

Exhibit 16: Maryland GME Funding per Medicare and Medicare Advantage Beneficiary Compared to National Funding

Spend Inputs	Maryland	Algebra	National	Algebra	Source	Link
MD Total and National IME Spending	$515,277,248	A	$10,100,000,000	A	ICC, MedPac June 2021 Report	http://www.medpac.gov/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf
MD Total and National Medicare DME Spending	$250,208,869	B	$3,800,000,000	B	ICC, MedPac June 2021 Report	http://www.medpac.gov/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf
Shares						
MC Share (incl. duals)	31.98%	C		C	Based on RY 2019 Data for Hospitals with Approved Residency Programs	
MA Share	3.60%	D		D		
CO Share	39.93%	E		E		
Medicaid	23.47%	F		F		
Total Including MA	98.98%	G=C+D+E+F		G=C+D+E+F		
Beneficiary Counts						
Medicare (including duals)	909,418	H	37,898,471	H	All from MC National Enrollment Report	https://www.cms.gov/files/document/2019cpsmdcrenrollab2.pdf
Medicare Advantage	127,535	I	22,344,144	I	All from MC National Enrollment Report	https://www.cms.gov/files/document/2019cpsmdcrenrollab2.pdf
Commercial	3,533,400	J		J		
Medicaid	951,400	K		K		
Total	**5,521,753**	L=H+I+J+K	**60,242,615**	L=H+I+J+K		
Spend Calculation						
Medicare	$ 247,325,824	M=(A+B)*C/G	$ 8,744,453,522	M=H/L*(A+B)		
Medicare Advantage	$ 27,844,133	N=(A+B)*D/G	$ 5,155,546,478	N=I/L*(A+B)		
Commericial	$ 308,826,927	O=(A+B)*E/G				
Medicaid	$ 181,489,232	P=(A+B)*F/G				
Total	**$ 765,486,117**	Q=M+N+O+P	**$13,900,000,000**	Q=M+N		
Check	$ -		$ -			
Per Resident 2019						
Residents	2,166	R	90,000	R	Maryland lesser of Schedule P and the Cap (by facility), National from MedPac Report	
Medicare FFS &MA Annual per Resident	$127,041	S=(M+N)/R	$154,444	S=(M+N)/R		
MD as a % of National	82.3%	T=R MD/R Nat'l				
Per Beneficiary						
Medicare FFS & Medicare Advantage	$265	U=(M+N)/(H+I)	$231	U=(M+N)/(H+I)		
MD Medicare & MA as % of National	115%	V=U MD/U Nat'l				
Total MD Excess Spending: Medicare FFS & Medicare Advantage	$35,909,980	W= (U MD - U Natl) * (H+I)				
Resident Projection if National Matched Maryland						
National Medicare Spending at MD Per Bene Rates			$15,986,219,033	X=U MD*L		
Number of Residents Funded at National Rate			103,508	Y=S/X		
Number of Additional National Residents Required to Equal MD's Per Ben Spending			13,508	Z=Y-R		

Summary of Findings

HSCRC staff has reviewed the quality, financial performance, and efficiency of PRMC over the last several years. The Hospital's quality performance is commendable in readmissions, hospital complications, and potentially avoidable utilization with the lone exception that avoidable admissions are in the fourth quintile of State performance. The Hospital has significant room for improvement in the Quality Based Reimbursement program, as it performs in the worst quintile for all assessments with the exception of patient experience, for which it performs in the second quintile. Average total operating margin from Fiscal Years 2014 through 2019, inclusive of unregulated losses, most notably physician subsidies, was 0.6 percent, which is the below the statewide average of 3.03 percent. Staff have determined that this is not a function of volume funding, as volume growth through CY 2019 (Fiscal Year 2019 for CDS-A eligible drugs) was overfunded by $7.4 million. This is also not a function of underfunding of regulated services generally, as regulated margins for Fiscal Year 2014 through 2019 was 11.0 percent, which is above the statewide average 8.23 percent. While the Hospital's total operating profit level is lower than the profits achieved by some other hospitals, the HSCRC evaluates cost efficiency of hospitals, and it does not guarantee hospital profit levels.

As outlined above, PRMC does not qualify for a rate increase under the ICC standard and the Hospital's assessment is further negatively scaled due to poor TCOC performance. In fact, it would receive a revenue decrease under the full rate application standard. See Exhibit 17 for the final full rate determination inclusive of all methodology and revenue enhancement considerations; staff have provided the rate determination with and without the approval of the first year of a residency program due to PRMC's genuine physician supply concerns and because there currently is not a standard or method by which to evaluate additional GME slots.

Exhibit 17: Summary of Components of Final ICC and TCOC Recommended Revenue for Peninsula Regional Medical Center*

FRA Methodology	Current Hospital Revenue Assessed	Revenue Change	FRA Recommend Revenue
ICC Efficiency Tool (Reflective of HSCRC Recommended Methodology Considerations)	$449.3 million	-$12.5 million	$436.8 million
Oncology Drugs	$14.1 million	$0	$14.1 million
TCOC Assessment	NA	-$2.2 million	-$2.2 million
Year 1 Child & Adolescent Behavioral Health Program	NA	$1.6 million	$1.6 million
Total	**$463.3 million**	**- $13 million**	**$450.3 million**
Year 1 GME for 10 Residents**	NA	$2.5 million	$2.5 million
Total with Approved Year 1 GME for 10 Residents	**$463.3 million**	**-$10.6 million**	**$452.7 million**

*Total may not add due to rounding, Values are denoted in Fiscal Year 2020 Dollars

** Approved amount would increase each year until program reached full maturity, which is estimated to be $15.9 million (65 residents X $244 thousand per resident)

Because PRMC has filed a full rate application, staff needs to make a recommendation on the Hospital's approved revenues. **As such, staff recommends adjusting the hospital's rate structure for a $13,043,455 revenue write-down or -2.82 percent, contingent on the Commission's determination that no additional funding should be provided to PRMC for a graduate medical education program. If the Commission elects to approve new residency slots at PRMC, staff recommend implementing a revenue write-down of $10,597,952 million or -2.29 percent to recognize the intended resident count (10) for the first year of the GME program and potentially restore that reduction after 5 years once the program has reached maturity in order to fund an additional 43 residents. In effect, this would allow PRMC to fund 53 residents or 82 percent of its projected program. Should the Commission determine that a new residency program at PRMC be funded through hospital rates, staff recommend that mandatory reviews occur. Specifically, the Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital forfeit any funding provided in rates for the GME program.**

Recommendation

HSCRC staff recommends that the Commission:

1) Consider adopting a statewide standard for funding additional residency slots in hospital rates. Specifically, until national funding of graduate medical education per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland, no additional funding for new residency slots should be provided in hospital rates.

2) Staff Recommendation for PRMC Full Rate Application - Implement a revenue write-down of $13,043,455 or -2.82 percent to reflect approval of:

a. PRMC's technical consideration to reduce McCready Hospital's revenue from its ICC evaluation
b. A 50 percent variable cost factor for growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025.
    i. All prospective adjustments for volume will be subject to retrospective review and settlement, including an accounting of volume funding received from the market shift methodology.
c. Establish a standard until national funding of GME per Medicare and Medicare Advantage beneficiaries reach levels equivalent to Maryland; no additional funding for new GME slots, including PRMC's request, should be provided in hospital rates.

Alternative

1) Staff Recommendation for PRMC Full Rate Application with GME **Alternative** - Implement a revenue write-down of $10,597,952 or -2.29 percent to reflect approval of:

a. PRMC's technical consideration to reduce McCready Hospital's revenue from its ICC evaluation
b. A 50 percent variable cost factor for growth in the adolescent behavioral health program until it reaches maturity in Fiscal Year 2025.
    i. All prospective adjustments for volume will be subject to retrospective review and settlement, including an accounting of volume funding received from the market shift methodology.
c. The establishment of a graduate medical education program for which 10 residents will receive credit for direct and indirect medical education in the current ICC evaluation
    i. The Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the

specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital forfeit any funding provided in rates for the GME program.

ii. The hospital may be allowed to apply for funding of the GME program each year and finally when the program reaches maturity after the 5th year. The Hospital must attest to providing the same residency specialty mix as outlined in the full rate application and must provide data on the retention of trained residents within the State of Maryland. If the specialty mix changes by more than 50 percent for any one category or if the retention rate falls below 50 percent, staff would recommend that the Hospital not qualify for restoration of any rate support for the GME program.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2400**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2590A**

Staff Recommendation

April 13, 2022

I. INTRODUCTION

On December 17, 2020, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular surgery with Quality Health Management. The Hospitals request that the Commission approve the arrangement for one year effective May 1, 2022.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payment, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that there was no activity under this arrangement for the prior year. However,

staff believes that the Hospitals can achieve a favorable outcome under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular surgery for one year beginning May 1, 2022. The Hospitals must file a renew application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2401**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2591A**

Staff Recommendation

April 13, 2022

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on March 28, 2022, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for Executive Health Services with Under Armor, Inc. for a period of one year beginning May 1, 2022.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION ANDASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC

maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement was positive for the last year. Staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services for a one-year period commencing May 1, 2022. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2402**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2592A**

Staff Recommendation

April 13, 2022

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on March 30, 2022 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a revised global rate arrangement with the Priority Partners Managed Care Organization. Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan for Spine and Bariatric surgery services. The System requests approval of the arrangement for a period of one year beginning May 1, 2022.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION ANDASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System

contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement for the last year has been slightly unfavorable. The Hospitals have adjusted the prices in their current arrangement to eliminate the losses. Staff believes that with the revised arrangement the Hospitals can achieve a favorable outcome.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Bariatric and Spine Surgery Procedures for a one year period commencing May 1, 2022. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

maryland
health services
cost review commission

Report Extending the Readmission Reduction Incentive Program for Rate Year 2024

April 13, 2021

This document extends the final staff recommendations for the Readmission Reduction Incentive Program, which was approved by the Commission on Jan 13, 2021, to RY 2024.

Introduction

With the commencement of the Total Cost of Care (TCOC) Model Agreement on January 1, 2019, the performance standards and targets in HSCRC's portfolio of quality and value-based payment programs have been reviewed and updated. In CY 2019, staff focused on the rate year (RY) 2022 RRIP program and convened a subgroup with clinical and measurement experts who made recommendations that were then further evaluated by the Performance Measurement Workgroup (PMWG). The RRIP subgroup and PMWG considered updated approaches for reducing readmissions in Maryland to support the goals of the TCOC Model. Specifically, the workgroup evaluated Maryland hospital performance relative to various opportunity analyses, including external national benchmarks, and developed a 5-year improvement target (2018-2023). In addition, the staff developed a within-hospital disparities metric for readmissions, which was linked with a Statewide Integrated Health Improvement Strategy (SIHIS) goal to have half of hospitals improve disparities by 50 percent.

The RY 2023 final recommendation, in general, maintained the measure updates and methodology determinations that were developed and approved for RY 2022.[1] Thus for RY 2024 staff propose to extend the RY 2023 policy with no significant changes. The RY 2023 final policy is included in the appendix.

Recommendations

These are the final recommendations for the RY 2023 Readmission Reduction Incentive Program (RRIP) policy:

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue,

[1] See the RY 2022 policy for detailed discussion of the RRIP redesign, rationale for decisions, and approved recommendations

5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years, capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Continue development of an all-payer Excess Days in Acute Care measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners as follows:

maryland
health services
cost review commission

Appendix: RY 2023 Final Policy

maryland health services cost review commission

Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2023

January 13, 2021

This document contains the final staff recommendations for the Readmission Reduction Incentive Program and was approved by the Commission on Jan 13, 2021.

maryland
health services
cost review commission

Table of Contents

maryland
health services
cost review commission

List of Abbreviations

ADI	Area Deprivation Index
AMA	Against Medical Advice
APR-DRG	All-patient refined diagnosis-related group
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
eCQM	Electronic Clinical Quality Measure
EDAC	Excess Days in Acute Care
FFS	Fee-for-service
HCC	Hierarchical Condition Category
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
HWR	Hospital-Wide Readmission Measure
MCDB	Medical Claims Database
MPR	Mathematica Policy Research
MSA	Metropolitan Statistical Area
NQF	National Quality Forum
PAI	Patient Adversity Index
PMWG	Performance Measurement Workgroup
PQI	Prevention Quality Indicators
RRIP	Readmissions Reduction Incentive Program
RY	Rate Year
SIHIS	Statewide Integrated Healthcare Improvement Strategy
SOI	Severity of illness
TCOC	Total Cost of Care
YTD	Year-to-date

maryland
health services
cost review commission

Key Methodology Concepts and Definitions

All Patients Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of diagnosis-related groups with severity of illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same diagnosis-related group and severity of illness level.

Observed/Expected Ratio: Readmission rates are calculated by dividing the observed number of readmissions by the expected number of readmissions. Expected readmissions are determined through case-mix adjustment.

Case-Mix Adjustment: Statewide rate for readmissions (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These statewide norms are applied to each hospital's case-mix to determine the expected number of readmissions, a process known as indirect standardization.

Prevention Quality Indicator (PQI): a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Area Deprivation Index (ADI): A measure of neighborhood deprivation that is based on the American Community Survey and includes factors for the theoretical domains of income, education, employment, and housing quality.

Patient Adversity Index (PAI): HSCRC developed composite measure of social risk incorporating information on patient race, Medicaid status, and the Area Deprivation Index.

Excess Days in Acute Care (EDAC): Capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

maryland health services cost review commission

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Readmission Reduction Incentive Program (RRIP), are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.	The RRIP policy is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.	The RRIP policy currently holds 2 percent of hospital revenue at-risk for readmissions occurring within 30-days of discharge for all payers and all causes. Specific criteria for inclusion (oncology discharges) and exclusion (discharges leaving Against Medical Advice, Planned Admissions) are detailed in Appendix I.	This policy affects a hospital's overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	Currently, the RRIP policy measures within-hospital disparities in readmission rates, using an HSCRC-generated Patient Adversity Index (PAI), and provides rewards for hospitals that meet specified disparity gap reduction goals. The broader RRIP policy continues to reward or penalize hospitals on the better of improvement and attainment, which incentivizes hospitals to improve poor clinical outcomes that may be correlated with health disparities. It is important that persistent health disparities are not made permanent. Moving forward, the assessment of performance may evolve the existing PAI measure, and the reward structure for improvements in within-hospital disparities in readmission rates.

Recommendations

The RRIP policy was redesigned in Rate Year (RY) 2022 to modernize the program for the Total Cost of Care Model. This RY 2023 final recommendation, in general, maintains the measure updates and methodology determinations that were developed and approved for RY 2022.[2]

These are the final recommendations for the RY 2023 Readmission Reduction Incentive Program (RRIP) policy:

8. Maintain the 30-day, all-cause readmission measure.
    a. Remove Pediatric Oncology cases, in accordance with the intention of the oncology readmission measure.

[2] See the RY 2022 policy for detailed discussion of the RRIP redesign, rationale for decisions, and approved recommendations

9. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.
10. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for maintaining low readmission rates.
11. For improvement and attainment, increase the maximum reward hospitals can receive to 2 percent of inpatient revenue and maintain the maximum penalty at 2 percent of inpatient revenue.
12. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years (>=15.91 percent reduction in disparity gap measure 2018 to 2021), capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years (>=29.29 percent reduction in disparity gap measure 2018 to 2021).
13. Continue development of an all-payer Excess Days in Acute Care measure in order to account for readmission, emergency department, and observation revisits post-discharge.
14. Adjust the RRIP pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners as follows:
    a. For RY 2022 (CY 2020 performance period)
        i. Exclude COVID-19 positive cases from the program.
        ii. Exclude the data for January to June 2020; evaluate whether to use the final six months of 2020 or whether to use a prior time period.
        iii. Evaluate case-mix adjustment and performance standards concerns arising from use of a pre-COVID time period to determine normative values.
    b. For RY 2023 (CY 2021 performance period) include COVID-19 positive cases but retrospectively assess any case-mix concerns, including the use of a pre-COVID time period to determine normative values.

Introduction

Since 2014, Maryland hospitals have been funded under a global budget system, which is a fixed annual revenue cap that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under the global budget system, hospitals are incentivized to transition services to the most appropriate care setting and may keep savings that they achieve via improved health care delivery (e.g., reduced avoidable utilization, such as readmissions or hospital-acquired infections). It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Quality programs reward quality improvements that reinforce the incentives of the global budget system, while penalizing poor performance and guarding against unintended consequences.

The Readmissions Reduction Incentive Program (RRIP) is one of several pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time. The RRIP currently holds up to 2 percent of inpatient hospital revenue at-risk in penalties and up to 1 percent at-risk in rewards based on improvement and attainment in case-mix adjusted readmission rates. In addition, the RRIP is the first quality policy to provide incentives for reducing disparities by rewarding hospitals up to 0.5 percent of inpatient hospital revenue for reducing within-hospital disparities in readmissions.

With the commencement of the Total Cost of Care (TCOC) Model Agreement on January 1, 2019, the performance standards and targets in HSCRC's portfolio of quality and value-based payment programs have been reviewed and updated. In CY 2019, staff focused on the RRIP program and convened a subgroup with clinical and measurement experts who made recommendations that were then further evaluated by the Performance Measurement Workgroup (PMWG). The RRIP subgroup and PMWG considered updated approaches for reducing readmissions in Maryland to support the goals of the TCOC Model. Specifically, the workgroup evaluated Maryland hospital performance relative to various opportunity analyses, including external national benchmarks, and staff developed a within-hospital disparities metric for readmissions in consultation with the workgroup.

Background

Brief History of RRIP program

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland had historically performed poorly compared to the nation on readmissions; it ranked 50th among all states in a study examining Medicare data from 2003-2004.[3] In order to meet the All-Payer Model requirements, the Commission approved the RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions.

As recommended by the Performance Measurement Workgroup, the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it is an all-cause measure that includes all patients and all payers.[4]

In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (such as planned readmissions) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment, with scaled rewards of up to 1 percent of inpatient revenue and scaled penalties of up to 2 percent.[5]

RRIP Redesign

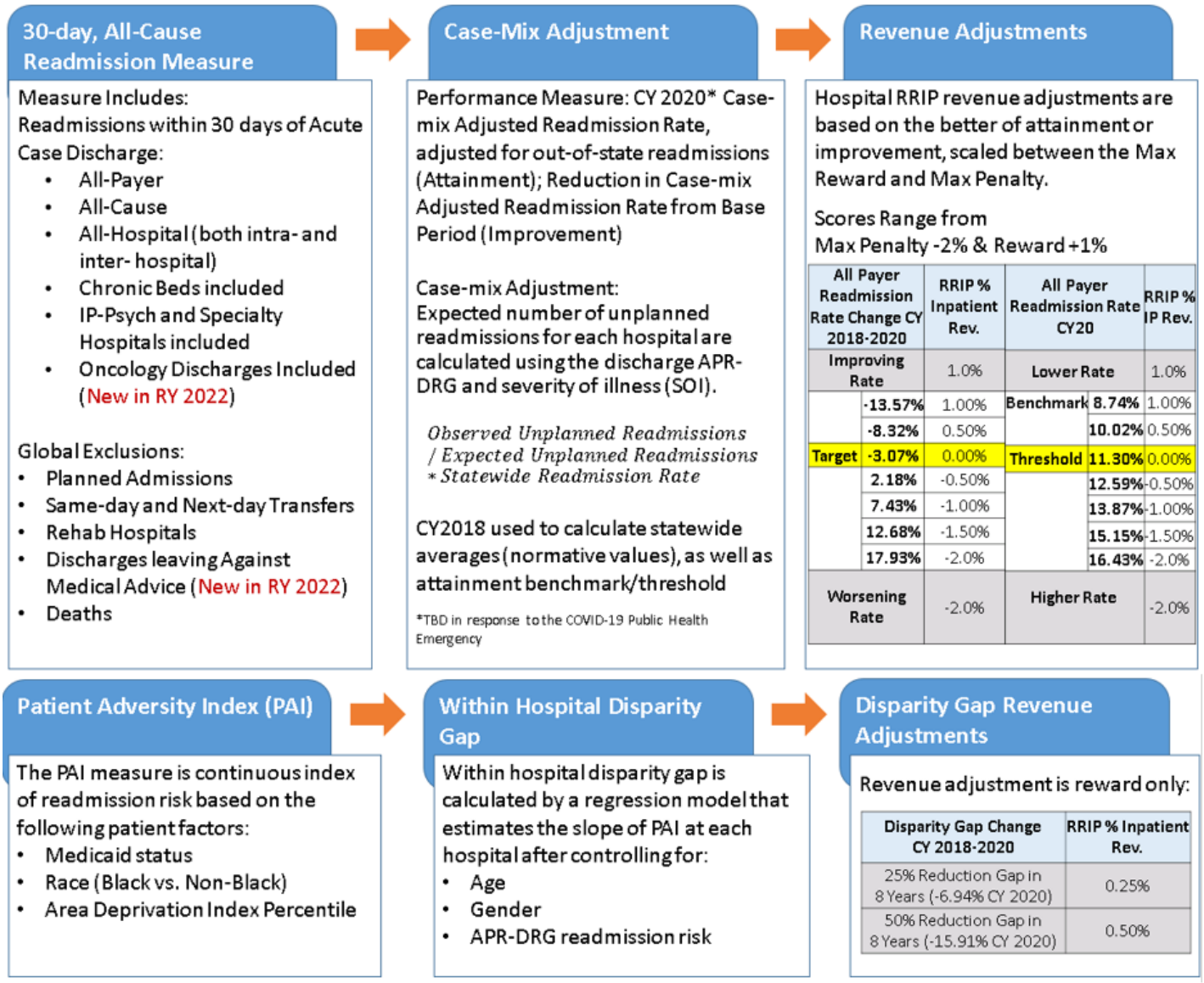
As part of the ongoing evolution of the All-Payer Model's pay-for-performance programs to further bring them into alignment under the Total Cost of Care Model, HSCRC convened a work group in CY 2019 to evaluate the Readmission Reduction Incentive Program (RRIP). The work group consisted of stakeholders, subject matter

[3] Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.
[4] For more information on the HRRP, please see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program. Maryland remains exempted from the federal HRRP.
[5] See Appendix I for details of the current RRIP methodology.

experts, and consumers, and met six times between February and September 2019. The work group focused on the following six topics, with the general conclusions summarized below:

1. Analysis of Case-mix Adjustment and trends in Eligible Discharges over time to address concern of limited room for additional improvement;
    - Case-mix adjustment acknowledges increased severity of illness over time
    - Standard Deviation analysis of Eligible Discharges suggests that further reduction in readmission rates is possible
2. National Benchmarking of similar geographies using Medicare and Commercial data;
    - Maryland Medicare and Commercial readmission rates and readmissions per capita are on par with the nation
3. Updates to the existing All-Cause Readmission Measure;
    - Remove Eligible Discharges that left against medical advice (~7,500 discharges)
    - Include Oncology Discharges with more nuanced exclusion logic
        - Additionally, remove pediatric oncology cases from readmission eligibility
    - Analyze out-of-state ratios for other payers as data become available
4. Statewide Improvement and Attainment Targets under the TCOC Model;
    - 7.5 percent Improvement over 5 years (2018-2023)
    - Ongoing evaluation of the attainment threshold at 65th percentile
5. Social Determinants of Health and Readmission Rates; and
    - Methodology developed to assess within-hospital readmission disparities
6. Alternative Measures of Readmissions
    - Further analysis of per capita readmissions as broader trend; not germane to the RRIP policy because focus of evaluation is clinical performance and care management post-discharge
    - Observation trends under the All-Payer Model to better understand performance given variations in hospital observation use; future development will focus on incorporation of Excess Days in Acute Care (EDAC) measure in lieu of including observations in RRIP policy
    - Electronic Clinical Quality Measure (eCQM) may be considered in future to improve risk adjustment

Figure 1. Overview Rate Year 2022 RRIP Methodology



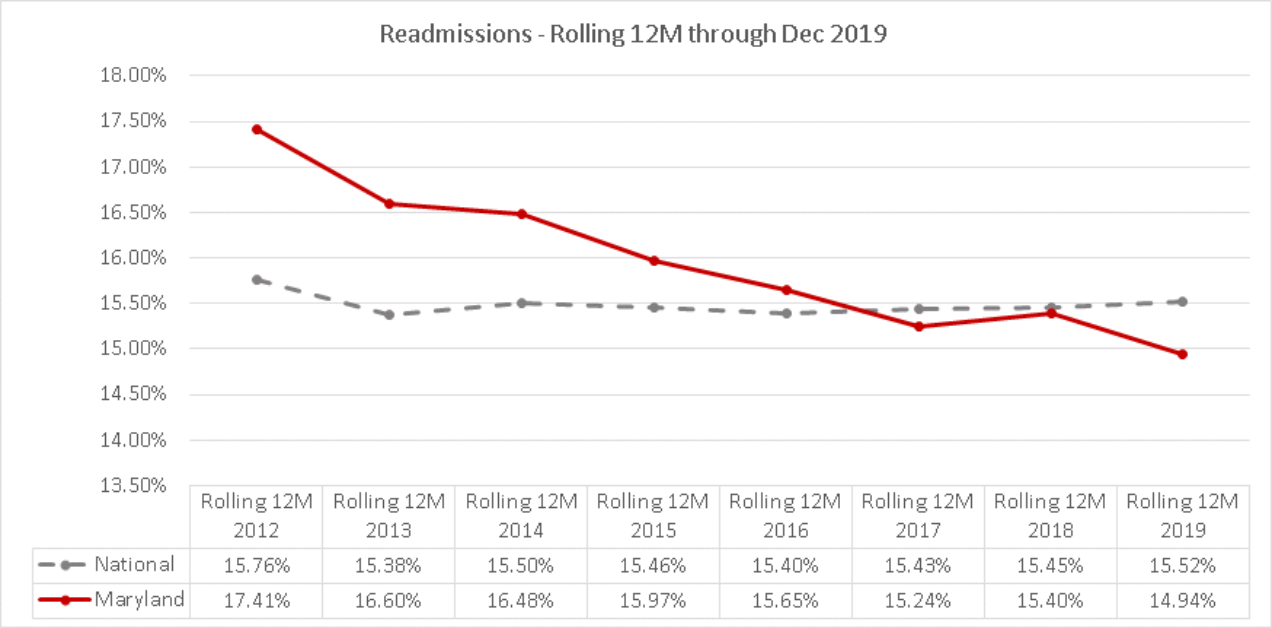
Assessment

In general, stakeholders support the staff's recommendation to not make major changes to the RY 2023 RRIP program. This section of the report provides an overview of the data and issues discussed by the PMWG, including analysis of CY 2019 statewide readmission rates, estimated hospital scores, and revenue adjustment modelling. Staff has not included CY 2020 YTD readmission rates due to the ongoing COVID-19 Public Health Emergency (see more below).

Statewide Readmissions Performance

In CY 2019, Maryland improved upon its All-Payer Model achievement of being at or below the National Medicare FFS Rate. In CY 2018 at the conclusion of the All-Payer Model, Maryland had an unadjusted Medicare readmission rate of 15.40%, compared to the national rate of 15.45%. Through CY 2019, Maryland further improved its readmission rate, concluding the year with a rate of 14.94% compared to the national rate of 15.52% (see Figure 2 below).

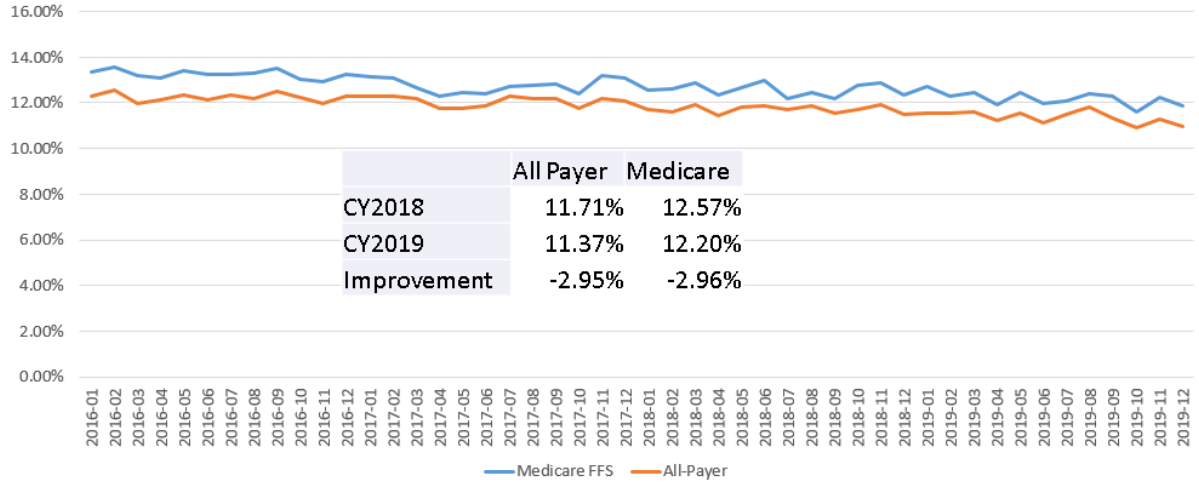
Figure 2. TCOC Model "Waiver Test" - Maryland and National Unadjusted Readmission Rates



	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018	Rolling 12M 2019
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%

Maryland also improved upon its Case-mix Adjusted Readmission rate in CY 2019, concluding CY 2019 with an all-payer case-mix adjusted readmission rate of 11.37%, a 2.90% reduction from the RY 2022 base period of CY 2018 (Figure 3, below). With the statewide improvement goal of 1.55% in CY 2020 (the compounded improvement needed to reach 7.5% over five years), 28 hospitals would have been "on track" to receive an incremental improvement reward for RY 2022, while 2 additional hospitals would have received the max reward for improvement.

Figure 3. RY 22 Monthly Case-mix Adjusted Readmission Rates, thru CY 2019



Given these favorable trends in readmission rates and given the challenges with assessing CY 2020 case-mix data during the COVID-19 Public Health Emergency (more below), staff is not recommending large changes to the RY 2023 RRIP policy, including maintaining the improvement and attainment methodologies for a planned CY 2021 performance period. The incremental improvement rate is assessed to be -4.57 percent, see Figure 4 below, while the attainment target benchmark and threshold will be calculated off of the most recent actionable case-mix data, adjusted for the proposed improvement (presently, CY 2019 under v37.1 of the APR-DRG grouper, yielding an attainment threshold of 10.96 percent and attainment benchmark of 8.16 percent). Based on the 2018 to 2019 readmission performance, there are 20 hospitals who have already exceeded the 4.57 percent improvement target such that if they maintain their 2019 readmission rates in 2021 they should receive an improvement reward.[6]

Figure 4. Compounded Improvement Rate to Achieve 7.5% Five-Year Improvement

Year	2019	2020	2021	2022	2023
Improvement	-1.55%	-3.07%	-4.57%	-6.05%	-7.50%

[6] Based on this preliminary attainment target one additional hospital would receive an attainment reward despite not meeting the improvement target.

COVID-19 Program Considerations

Staff notes that, on September 2, 2020, CMS published an Interim Final Rule (IFR) in response to the COVID-19 PHE. In this IFR, they announced that:

- CMS will not use CY Q1 or CY Q2 of 2020 quality data even if submitted by hospitals.
- CMS is still reserving the right to suspend application of revenue adjustments for FFY 2022 for all hospital pay for performance programs at a future date in 2021; changes will be communicated through memos ahead of IPPS rules.

It is not known at this time if Maryland has flexibility in suspending our RY 2022 programs. However, CMMI has strongly suggested that the State must have quality program adjustments, and has further suggested that the State pursue alternative strategies, such as reusing portions of CY 2019 (as is being done for the Skilled Nursing Facility VBP program) to create a 12-month performance period, should that be necessary for data reliability and validity.

In context of the CMS announcement and CMMI comments, staff has evaluated the data issues and options for the RY 2022 RRIP policy in Maryland, as illustrated in Figure 5 below.

Figure 5. RY 2022 COVID-Related Data Concerns and Options

COVID Data Concerns	Options
Only 6 months of data for CY 2020: 1. Is July-December data reliable? 2. What about seasonality?	• Use 6-months data, adjust base as needed for seasonality concerns • Merge 2019 and 2020 data together to create a 12 month performance period • Use 2019 data or revenue adjustments
Clinical concerns over inclusion of COVID patients	• Remove COVID patients from CY 2020 Eligible Discharges or Readmissions
Case-mix adjustment, performance standard and revenue adjustment scale concerns: 1. Inclusion of COVID patients when not in normative values 2. Impacts on other DRG/SOI of COVID PHE	• Remove COVID patients from CY 2020 evaluation • Develop concurrent norms and performance standards for comparison and possible use • Use 2019 data or revenue adjustments • Modify revenue adjustment scale to recognize COVID related concerns

At this stage, staff believes the most appropriate approach for the RRIP policy is to exclude the COVID-19 patients[7] if any CY 2020 data is used. Over the coming months, staff will work to assess any case-mix adjustment and performance standard issues due to the absence of COVID-19 patients in the base period and normative values, and to finalize the performance period. Staff will provide updates to the Commission in February, at the earliest, on the final decisions for any adjustments to all RY 2022 quality policies.

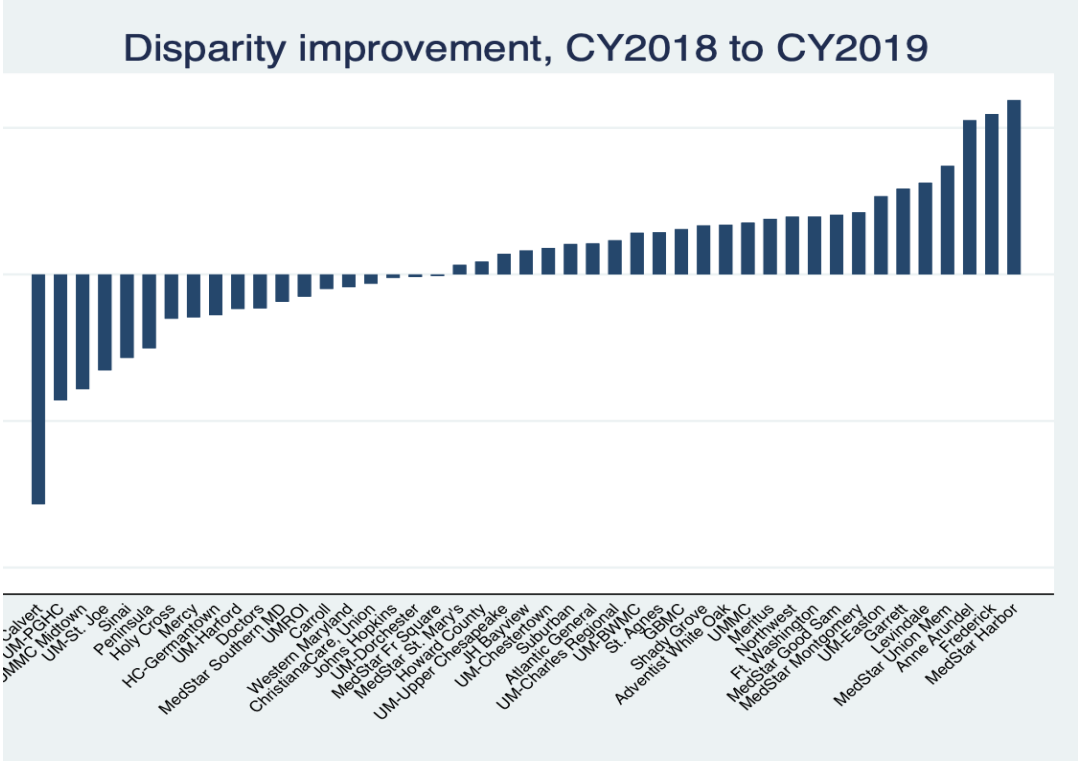
For RY 2023, the program will use v38 of the APR-DRG grouper, however, unlike the v38 PPC grouper, this updated grouper does not make changes to the readmission flags to account for COVID-19. Staff will need to consider any additional modifications to address case-mix adjustment and performance standard concerns that may arise from inclusion of COVID-19 positive patients in the performance period, especially since COVID-19 cases were not part of the statewide normative values. Furthermore, based on stakeholder comments, analyses should be done on case-mix adjustment and performance standards concerns for non-COVID patients.

Within-Hospital Disparities in Readmissions

In March 2020 the Commission approved rewards for hospitals reducing socioeconomic disparities in readmission rates between CY2018 and CY2020.[8] Evaluation of performance for CY2019 showed 26 of 45 hospitals improved on the disparity measure (Figure 6).

[7] COVID-19 cases are defined as those coded with the ICD10 code U07.1
[8] Details on the methodology for calculating within hospital disparities can be found in the RY 2022 RRIP policy

Figure 6: CY2019 Disparity Improvement[9]



Of those that improved, four would be ineligible for disparity reward due to overall RRIP performance requirement of some improvement, and one was not on track to attain the minimum disparity gap improvement threshold. Two hospitals are on track for a reward of 0.25% IP revenue and 19 are on track for a reward of 0.50% IP revenue.

Staff recommended the currently approved reward targets after reviewing analytics suggesting significant change in disparities would be difficult and time consuming for hospitals to achieve. However, as the program developed, Staff implemented a change in the calculation procedure to better account for shifting PAI values at individual hospitals. Specifically, initial analytics for the program were developed with the Patient Adversity Index (PAI), which measures patient socioeconomic exposures, using claims from CY2016 to 2018, which had the effect of stabilizing hospital disparity levels estimated annually during that three-year period. Ultimately, however, Staff elected to measure PAI, and to calculate mean PAI for each hospital, using data only from CY2018 to more accurately reflect PAI values, readmission risk, and performance during the base year, rather than during years not included in the base. This led to a larger-than-anticipated number of hospitals qualifying for the maximum reward category for RY 2022.

[9] This graph does not show the absolute difference in readmission rates between Medicaid and other payers, black vs non black, and high ADI vs low ADI, and nor does it represent the change in readmission rates for these groups, but rather this graph shows the change in the disparity gap over time between the groups as determined through an evaluation of the change in slope for readmissions across all levels of patient adversity at each hospital.

Because of this methodology change, Staff recommends updating the reward structure to provide rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years (>=15.91 percent reduction in disparity gap measure 2018 to 2021), and 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years (>=29.29 percent reduction in disparity gap measure 2018 to 2021).[10] Under this approach, six hospitals are currently on track to receive the lower reward, and 13 on track to receive the higher one. Staff also tends to evaluate approaches to scaling rewards between the lower and higher points.

Staff has received feedback from stakeholders suggesting that a review of initial program results to evaluate the possibility of unintended consequences related to the policy, such as shifts in coding of patient race. This work is planned for early 2021. Additionally, Staff is aware of the need to develop an approach to accounting for the effect of COVID-19 on disparities measurement.

Hospital Score and Revenue Adjustment Modeling

For this final policy, staff modeled hospital performance and revenue adjustments as if the policy had been applied from the base of 2018 to the 2019 performance year. This was done by calculating the one-year improvement targets for both case-mix adjusted readmissions and the disparity gap, i.e. 1.55 percent for readmissions and 3.53 percent (25 percent target) and 8.30 percent (50 percent target) for disparities. Furthermore, the attainment target was updated to what it would have been if it had been set at the 65th percentile of CY 2018 performance.

Using the readmission measure that was approved for RY 2022, staff modeled improvement for 2018 to 2019 and 2019 attainment.[11] The revenue adjustment scales for improvement and attainment were created as if the RY 2022 policy had been in place for 2019 performance. In addition staff modeled the disparity gap in 2018 and 2019 to assess improvement compared to the one year improvement goal needed to achieve a 25 and 50 percent reduction in disparities over 8 years. Based on the combined revenue adjustments for the better of improvement or attainment and the disparity gap reward, 13 hospitals would be penalized for a total of $7.5 million and 32 hospitals would be rewarded for a total of $41.7 million. Approximately half of the rewards ($20.3 million) are due to reductions in disparities between 2018 and 2019. Specifically, 19 hospitals had disparity gap reductions of greater than 8.30 percent (putting them on track to reduce disparities by 50 percent over 8 years and earning then 0.50 percent inpatient revenue reward) and 2 hospitals had disparity gap reductions of greater than 3.53 percent (putting them on track for 25 percent reduction over 8 years and earning them a 0.25 percent inpatient revenue reward). Based on this modeling, staff have proposed to raise the expectations for disparity reductions in order to begin earning a reward and plan to scale the rewards (i.e., make continuous) from those on track for a 50 percent improvement starting to earn reward and those on track for a 75 percent reward getting the full 0.50 percent reward.

Figure 7: Modeling of 2018-2019 Readmissions Performance

[10] Five hospitals have already improved by greater than 29.29 percent CY 2018 to CY 2019

[11] Please note that this modeling was not updated to exclude pediatric oncology - per the Stakeholder Feedback section, pediatric oncology discharges are approximately 50 eligible discharges annually.

Statewide Revenue Adjustment Modeling	Improvement/Attainment Case-Mix Adjusted Readmission Rate		Disparity Gap Reduction Reward		Total Combined Revenue Adjustment	
	$	%	$	%	$	%
Net	$13,947,627	0.14%	$20,288,666	0.21%	$34,236,293	0.35%
Penalties	-$7,891,071	-0.08%			-$7,478,827	-0.08%
Rewards	$21,838,698	0.23%	$20,288,666	0.21%	$41,715,120	0.43%
# Hospitals Penalized	16		21		13	
# Hospitals Rewarded	29		24		32	

Additional Future Considerations

It remains important that the HSCRC continue to compare Maryland readmission rates against national readmission rates to evaluate relative Maryland performance. Staff is presently working with CMMI to better understand the federal Hospital-wide Readmission (HWR) measure, which is publicly posted on CMS Hospital Compare once a year. It may be advantageous to better understand the federal HWR measure, as it includes a risk-adjustment; the "Waiver Test" readmission rate for Maryland is presently an unadjusted readmission rate, which may present future challenges as Maryland reduces unnecessary utilization and simultaneously increases the case-mix index of remaining eligible discharges. Additionally, a Hybrid HWR Measure was adopted by CMS in 2018 as a voluntary measure under the Hospital Inpatient Quality Reporting Program. The Hybrid HWR Measure differs from the claims-based HWR measure, as it merges electronic health record (EHR) data elements with claims data to calculate the risk-standardized readmission rate.[12] Staff will consider potential use(s) of the HWR/HWR Hybrid measure in the future.

As mentioned above, staff will need to evaluate the implications of the COVID-19 Public Health Emergency on all pay-for-performance programs, including the RRIP. Finally, staff continue to work with Mathematica Policy Research (MPR), our contractor, to operationalize an all-payer measure of Excess Days in Acute Care, which would incorporate admissions, observation stays, and ED visits within 30 days of an acute care discharge. Staff appreciates the opportunity to continue to evolve this policy under the TCOC Model.

Stakeholder Feedback and Staff Response

The HSCRC received three comment letters, from the Maryland Hospital Association, the Johns Hopkins Healthcare System, and Luminis Health. The letters shared broad agreement with maintaining the recently redesigned RRIP as is, and made the following topical suggestions:

1. **Lower the improvement target from three-years (4.57%) to two-years (3.07%)** in acknowledgement of the COVID-19 pandemic and the unreliability of the CY 2020 data.

[12] For additional information, see: https://qualitynet.cms.gov/inpatient/measures/hybrid

Response: Per the "Assessment" section above, just under half of MD hospitals (20) improved greater than 4.57% in one year, 2018-2019. We believe the five-year improvement remains reasonable and achievable; staff does not agree with the suggestion.

2. **Increase the maximum reward to 2%**, to align with the other quality, pay-for-performance programs.

   Response: Staff appreciates the commitment to symmetry across the pay-for-performance quality programs; and notes the historical improvement of Maryland hospitals with regard to readmission rates.

   Staff would also note the following:

   - A required further reduction of 7.5% over the 5 years of the TCOC Model after successfully reducing readmissions by ~15% during the All-Payer Model and the ultimate goal of moving the State to the 25th percentile of benchmark peers will require additional resources.
   - RRIP is the only Quality pay-for-performance policy that does not have symmetrical risk, which adds complexity to the policy.
   - The Commission routinely incentivizes hospitals to reduce readmissions through the Potentially Avoidable Utilization Shared Savings program by removing inflation from readmissions and avoidable admissions, thereby maintaining a greater emphasis on downside risk in readmissions.

   Staff therefore agrees with this suggestion to raise the maximum reward to 2 percent.

3. **"Blend" the base year to be a combination of multiple years**, so that one particularly good or bad base year does not have an outsized influence on potential improvement.

   Response: Currently the Maryland quality programs that assess improvement have a one year base period (or equal base period time frame as the performance period). This has been true for RRIP since its start where the base period was locked in at 2013 or 2016 (post ICD-10) and staff do not recall this being brought up as a stakeholder concern during the RRIP redesign. In addition, at a statewide level there is fairly high correlation in readmission rates year over year despite overall reductions in readmissions, suggesting that there is limited year over year volatility in hospital's readmission rate and widespread improvement in readmissions, which hospitals get credit for in the RRIP policy. Last, hospitals with a low readmission rate in the base period still have opportunities for attainment rewards under the policy.

4. In agreement with Commissioner Elliott, **remove pediatric oncology cases** from readmission eligibility.

   Response: Staff agrees, and thanks Commissioner Elliott for bringing this to our attention.

   Preliminary modeling suggests that the removal of pediatric oncology cases will result in little material impact, with approximately 50 annual eligible discharges affected. However, this measure update will further align the oncology discharges within the readmission measure with the intention of the measure steward.

5. JHHS recommended changing the **RRIP disparity component to provide rewards for past progress already achieved.**

   Response: Staff does not support inclusion of attainment rewards over the near term. The Commission's approach with the overall RRIP policy has been to focus on incenting improvement during the initial years of the policy, and the current disparity component is consistent with that approach. Secondly, unless the disparity threshold were set at zero, an attainment policy would have the effect of classifying some level of disparity as acceptable and suitable for reward. Staff does not believe this approach would ultimately result in an equitable healthcare system.

6. Continue to **evaluate the validity of the Excess Days in Acute Care (EDAC) measure**, including "factors that contribute to Emergency Department and Observation Revisits".

   Response: Staff appreciates this feedback and will continue to work with our stakeholder workgroup as we evaluate this measure. Currently staff have engaged Mathematica to develop an all-payer version of this measure, which staff at this time would see as additive to the program and not designed to necessarily replace the current readmission measure.

7. One stakeholder letter requested clarification on the **flags defining COVID positive patients**, and how COVID-positive cases transferred to a hospital would be accounted for in the RRIP policy.

   Response: COVID positive flag is presently U07.1 per CDC guidelines. Should these guidelines change we will follow the updated CDC guidelines. All patients transferred from one acute care hospital to another (discharged and then admitted within the same day or next-day) are excluded from counting as a readmission from the transferring hospital within the RRIP. These patients are counted as an eligible discharge for the receiving hospital. The current case-mix adjustment severity of illness will reflect the higher risk of readmission to transfer patients. However, the HSCRC can examine the specific risk to COVID positive patients retrospectively.

8. Finally, the Maryland Hospital Association reiterates that the COVID-19 public health emergency is ongoing and unprecedented. As such, MHA notes that the **CY 2020 data is unreliable and should not be used in any RY 2022 pay-for-performance assessment of quality, and that RY 2022 pay-for-performance programs should be suspended.**

Response: Staff appreciates this viewpoint and notes that Maryland currently has no latitude to discontinue RY 2022 pay-for-performance revenue adjustment, as CMS and by extension CMMI have not as yet agreed to a blanket suspension of RY 2022 pay-for-performance programs. Should the federal government decide to suspend these programs, staff will advocate to include Maryland in that suspension. At present, staff is working with statisticians, subject-matter experts, and stakeholders to ascertain how best to apply revenue adjustments in FY 2022 (for RY 2022 programs). We appreciate stakeholder feedback on this endeavor.

Recommendations

1. Maintain the 30-day, all-cause readmission measure.
    a. Remove Pediatric Oncology cases, in accordance with the intention of the oncology readmission measure.
2. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for maintaining low readmission rates.
4. For improvement and attainment, increase the maximum reward hospitals can receive to 2 percent of inpatient revenue and maintain the maximum penalty at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years (>=15.91 percent reduction in disparity gap measure 2018 to 2021), capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years (>=29.29 percent reduction in disparity gap measure 2018 to 2021).
6. Continue development of an all-payer Excess Days in Acute Care measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners as follows:
    a. For RY 2022 (CY 2020 performance period)
        i. Exclude COVID-19 positive cases from the program.
        ii. Exclude the data for January to June 2020; evaluate whether to use the final six months of 2020 or whether to use a prior time period.
        iii. Evaluate case-mix adjustment and performance standards concerns arising from use of a pre-COVID time period to determine normative values.
    b. For RY 2023 (CY 2021 performance period) include COVID-19 positive cases but retrospectively assess any case-mix concerns, including the use of a pre-COVID time period to determine normative values.

Appendix I. Readmission Measure Specifications and Revenue Adjustment Methodology

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.[13] Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

2) Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.[14] Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.[15]
- New in RY 2022: Remove DRG oncology exclusion but continue to exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.[16]
- New in RY 2022: Exclude patients with a discharge disposition of Left Against Medical Advice (PAT_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.
- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission;

[13] Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].
[14] **Rehab** DRGs: 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs**: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[15] **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[16] **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

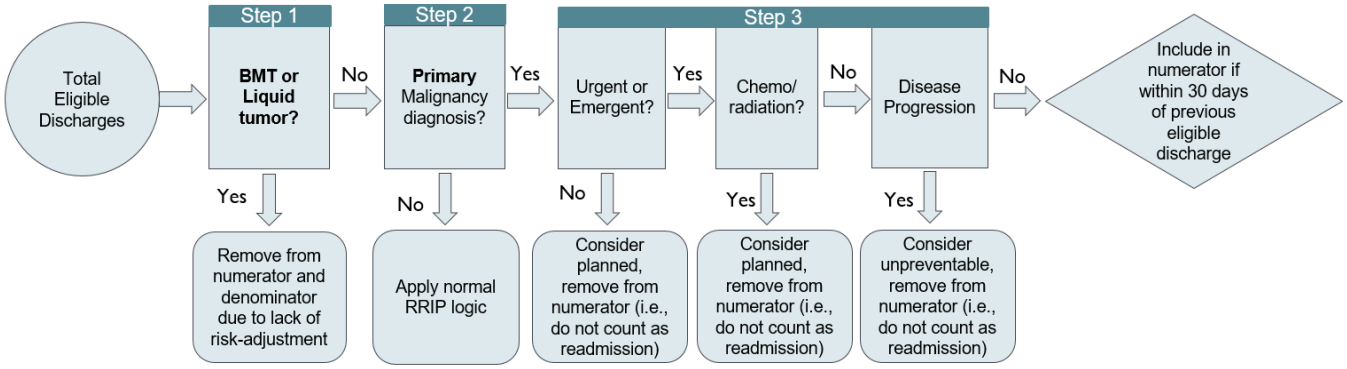
however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.

- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
    - Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
    - Duplicates are removed.
    - Negative interval days are removed.

      HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



*Items that are **bolded** are adaptations from NQF measure

This updated logic replaces the RY 2021 measure logic that removes all oncology DRGs from the dataset, such that an admission with an oncology DRG cannot count as a readmission or be eligible to have a readmission.

Step 1: Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer

hospital measure that risk-adjusts for bone marrow transplant and liquid tumors. HSCRC staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

Step 2: Flag discharges with a primary malignancy diagnosis to apply cancer specific logic for determining readmissions. This varies from the NQF cancer hospital measure that flags patients with primary or secondary malignancy diagnosis being treated in a cancer specific hospital. Staff think we should only flag those with a primary diagnosis since in a general acute care hospital there may be differences in the types of patients with a secondary malignancy diagnosis. Further, we remove the bone marrow and liquid tumor discharges regardless of malignancy diagnosis, thus ensuring the most severe cases are removed. Last, our initial analyses did not show a large impact on overall hospital rates when primary vs primary and secondary malignancies were flagged. It should be noted however that the current modeling in this policy uses readmission rates where both primary and secondary are flagged.

Step 3: Flag planned admissions using additional criteria beyond the CMS planned admission logic:

a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned
c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission

In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2018 base period and CY 2020 performance period, data from January 1 through

December 31, plus 30 days in January of the next year are used. The base period data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below, as well as the estimated CY 2018 readmission rates.

Please note that, the base year readmission rates are not "locked in", and may change if there are CRISP EID or other data updates. The HSCRC does not anticipate changing the base period data, and does not anticipate that any EID updates will change the base period data significantly; however, the HSCRC has decided the most up-to-date data should be used to measure improvement. For the performance period, the CRISP EIDs are updated throughout the year, and thus, month-to-month results may change based on changes in EIDs.

SOFTWARE: APR-DRG Version 38 for CY 2018-CY 2021.

Calculation:

$$\text{Case-Mix Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} * \text{Statewide Base Year Readmission Rate}$$

Numerator: Number of observed hospital-specific unplanned readmissions.

Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions, adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

Calculate the Statewide Readmission Rate without Planned Readmissions.

- Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

For each hospital, enumerate the number of observed, unplanned readmissions.

For each hospital, calculate the number of expected unplanned readmissions at the APR-DRG SOI level (see Expected Values for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data.

Calculate at the hospital level the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.

Multiply the O/E ratio by the base year statewide rate, which is used to get the case-mix adjusted readmission rate by hospital. Multiplying the O/E ratio by the base year state rate converts it into a readmission rate that can be compared to unadjusted rates and case-mix adjusted rates over time.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals, given its mix of patients as

defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being "eligible" for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of eligible discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm
P = Number of discharges with a readmission
D = Number of eligible discharges
i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, the expected rate is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display the expected rate as a rate per one thousand.

Once a set of norms has been calculated, the norms are applied to each hospital's DRG and SOI distribution. In the example below, the computation presents expected readmission rates for a single diagnosis category and its four severity levels. This computation could be expanded to include multiple diagnosis categories, by simply expanding the summations.

Consider the following example for a single diagnosis category.

Expected Value Computation Example – Individual APR-DRG

A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	**500**	**45**	**.09**		**56.5**

For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the total number of discharges at risk for readmission (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each severity level for that diagnosis category is displayed in column E. The expected number of readmissions for each severity level shown in column F is calculated by multiplying the number of eligible discharges (column B) by the normative readmissions per discharge rate (column E) The total number of readmissions expected for this diagnosis category is the sum of the expected numbers of readmissions for the 4 severity levels.

In this example, the expected number of readmissions for this diagnosis category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

4) Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 1 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high level overview of the RY 2021 RRIP methodology for reference. For RY 2022 RRIP methodology, please see figure 1 within the policy.

Overview Rate Year 2021 RRIP Methodology

RRIP Performance Metric

Measure: All-Payer, 30-day, all-cause readmissions using CRISP unique identifier to track patients across acute hospitals in Maryland

Case-Mix Adjustment: Indirect standardization by diagnosis and severity of illness levels to calculate hospital expected readmissions given the patient mix and acuity

Discharges Ineligible for Readmission: transfers, deaths, oncology, rehab, newborns, APR-DRG SOI cells <2 discharges statewide, missing or ungroupable data

Unplanned Readmissions Only: Planned admissions (based on CMS logic) are not counted as readmissions (but are eligible for an unplanned readmission)

Improvement: Change in readmission rate from base period (RY 2022: CY16-CY19)

Attainment: All-payer readmission rate is adjusted to account for out of state readmissions using Medicare ratio of in-state vs. out-of-state readmissions

Revenue Adjustments: Better of Improvement or Attainment

Improvement

	Change in Readmission Rate	Percent Adjustment
Improving ➡	**-14.40%**	1.00%
	-9.15%	0.50%
	-3.90%	0.00%
	1.35%	-0.50%
	6.60%	-1.00%
	11.85%	-1.50%
Worsening ➡	**17.10%**	-2.0%

Max Penalty = 2%
Max Reward = 1%

Attainment

	Readmission Rate w/ Out-of-State	Percent Adjustment
Benchmark ➡	**8.94%**	1.00%
	10.03%	0.50%
Threshold ➡	**11.12%**	0.00%
	12.21%	-0.50%
	13.30%	-1.00%
	14.39%	-1.50%
	15.47%	-2.0%

maryland health services cost review commission

Appendix II. RRIP Revenue Adjustment Modeling

Please note: These figures model RY 22 RRIP with CY 2018 Base period and CY 2019 Performance Period (i.e., using a one-year improvement target based on the RY 2022 readmission measure and the RY 22 at-risk amounts for rewards of 1% and penalties of 2%).

RY 22 RRIP for Modeling – CY 18 Base; CY 19 Perf				Imp	Attainment Scaling		Improve/Attain Final Adjustment			Disparity Gap				Combined Revenue Adjustment	
HOSP ID	HOSP NAME	RY 19 Estimated Permanent Inpatient Revenue	CY18-CY19 % Δ in CM Adj Rate	% Rev Adj For Imp - 1.55%	CY18 CM Adj Rate w OOS Adj	% Rev Adj 35th % 10.7%	$ Better of Att or Imp	RY20 Final % Rev Adj	Imp or Att	CY18-CY19 % Δ in Gap	Elig?	% Rev Adj	$ Rev Adj	% Rev Adj	$ Rev Adj
210001	MERITUS	$219,551,750	-6.24%	0.45%	11.06%	-0.12%	$987,983	0.45%	Imp	-18.99%	Yes	0.5%	$1,097,759	0.95%	$2,085,742
210002	UMMC	$1,203,673,856	-3.15%	0.15%	13.14%	-0.82%	$1,805,511	0.15%	Imp	-17.68%	Yes	0.5%	$6,018,369	0.65%	$7,823,880
210003	UM-PG	$282,929,188	-5.11%	0.34%	12.43%	-0.58%	$961,959	0.34%	Imp	42.94%	Yes	0.0%	$0	0.34%	$961,959
210004	HOLY CROSS	$355,608,692	-2.47%	0.09%	12.40%	-0.57%	$320,048	0.09%	Imp	15.12%	Yes	0.0%	$0	0.09%	$320,048
210005	FREDERICK	$232,665,827	-1.23%	-0.03%	10.96%	-0.09%	-$69,800	-0.03%	Imp	-54.71%	Yes	0.5%	$1,163,329	0.47%	$1,093,529
210006	UM-HARFORD	$54,181,186	0.00%	-0.15%	11.62%	-0.31%	-$81,272	-0.15%	Imp	11.76%	No	0.0%	$0	-0.15%	-$81,272
210008	MERCY	$226,492,002	-3.57%	0.19%	12.75%	-0.69%	$430,335	0.19%	Imp	14.65%	Yes	0.0%	$0	0.19%	$430,335
210009	JHH	$1,456,687,424	0.08%	-0.15%	13.67%	-0.99%	-$2,185,031	-0.15%	Imp	1.20%	No	0.0%	$0	-0.15%	-$2,185,031
210010	UM-DORCHEST	$22,653,845	-4.50%	0.28%	9.64%	0.36%	$81,554	0.36%	Att	0.90%	Yes	0.0%	$0	0.36%	$81,554
210011	ST. AGNES	$238,757,730	-4.94%	0.32%	11.61%	-0.30%	$764,025	0.32%	Imp	-14.38%	Yes	0.5%	$1,193,789	0.82%	$1,957,814
210012	SINAI	$399,817,673	-6.66%	0.49%	11.05%	-0.12%	$1,959,107	0.49%	Imp	28.48%	Yes	0.0%	$0	0.49%	$1,959,107
210015	MS-FR SQ	$306,898,504	-5.36%	0.36%	12.62%	-0.64%	$1,104,835	0.36%	Imp	0.53%	Yes	0.0%	$0	0.36%	$1,104,835
210016	WASH ADV	$164,197,283	-3.17%	0.15%	11.71%	-0.34%	$246,296	0.15%	Imp	-16.96%	Yes	0.5%	$820,986	0.65%	$1,067,282
210017	GARRETT	$23,714,400	-32.57%	1.00%	7.94%	0.92%	$237,144	1.00%	Imp	-29.27%	Yes	0.5%	$118,572	1.50%	$355,716

210018	MS-MONTG	$84,721,645	-13.13%	1.00%	10.91%	-0.07%	$847,216	1.00%	Imp	-21.21%	Yes	0.5%	$423,608	1.50%	$1,270,824
210019	PRMC	$249,228,264	-10.55%	0.86%	10.49%	0.07%	$2,143,363	0.86%	Imp	25.22%	Yes	0.0%	$0	0.86%	$2,143,363
210022	SUBURBAN	$208,954,270	-9.41%	0.75%	11.31%	-0.20%	$1,567,157	0.75%	Imp	-10.38%	Yes	0.5%	$1,044,771	1.25%	$2,611,928
210023	AAMC	$294,544,506	2.44%	-0.38%	12.15%	-0.49%	-$1,119,269	-0.38%	Imp	-52.60%	No	0.0%	$0	-0.38%	-$1,119,269
210024	MS-UNION	$243,156,679	-3.35%	0.17%	11.99%	-0.43%	$413,366	0.17%	Imp	-37.04%	Yes	0.5%	$1,215,783	0.67%	$1,629,149
210027	WESTERN MARYLAND	$169,462,000	2.60%	-0.39%	12.65%	-0.65%	-$660,902	-0.39%	Imp	4.34%	No	0.0%	$0	-0.39%	-$660,902
210028	MS-ST. MARY	$79,141,046	-5.85%	0.41%	12.41%	-0.57%	$324,478	0.41%	Imp	-3.28%	Yes	0.0%	$0	0.41%	$324,478
210029	JHBAYVIEW	$366,607,627	-3.64%	0.20%	13.76%	-1.02%	$733,215	0.20%	Imp	-8.22%	Yes	0.25%	$916,519	0.45%	$1,649,734
210030	UM-CHESTER	$17,859,942	-7.44%	0.56%	7.80%	0.97%	$173,241	0.97%	Att	-9.04%	Yes	0.5%	$89,300	1.47%	$262,541
210032	UNION OF CECIL	$65,426,887	3.91%	-0.52%	13.34%	-0.88%	-$340,220	-0.52%	Imp	3.19%	No	0.0%	$0	-0.52%	-$340,220
210033	CARROLL	$140,291,849	3.14%	-0.45%	12.35%	-0.55%	-$631,313	-0.45%	Imp	4.95%	No	0.0%	$0	-0.45%	-$631,313
210034	MS-HARBOR	$110,392,040	-6.97%	0.52%	13.42%	-0.91%	$574,039	0.52%	Imp	-59.46%	Yes	0.5%	$551,960	1.02%	$1,125,999
210035	UM-CHARL	$76,930,098	-1.92%	0.04%	12.07%	-0.46%	$30,772	0.04%	Imp	-11.66%	Yes	0.5%	$384,650	0.54%	$415,422
210037	UM-EASTON	$103,481,053	-5.16%	0.34%	9.31%	0.47%	$486,361	0.47%	Att	-26.70%	Yes	0.5%	$517,405	0.97%	$1,003,766
210038	UM-MID	$111,141,002	-3.05%	0.14%	14.52%	-1.28%	$155,597	0.14%	Imp	39.17%	Yes	0.0%	$0	0.14%	$155,597
210039	CALVERT	$67,111,996	8.12%	-0.92%	12.26%	-0.52%	-$348,982	-0.52%	Att	78.42%	No	0.0%	$0	-0.52%	-$348,982
210040	NORTHWE	$138,719,920	-11.31%	0.93%	10.47%	0.08%	$1,290,095	0.93%	Imp	-19.72%	Yes	0.5%	$693,600	1.43%	$1,983,695
210043	BWMC	$250,217,336	-0.85%	-0.07%	11.79%	-0.37%	-$175,152	-0.07%	Imp	-14.23%	Yes	0.5%	$1,251,087	0.43%	$1,075,935
210044	G.B.M.C.	$237,787,317	1.13%	-0.25%	10.93%	-0.08%	-$190,230	-0.08%	Att	-15.43%	No	0.0%	$0	-0.08%	-$190,230
210048	HOWARD	$182,870,977	2.42%	-0.38%	11.62%	-0.31%	-$566,900	-0.31%	Att	-4.38%	No	0.0%	$0	-0.31%	-$566,900
210049	UM-UCH	$128,686,091	-0.17%	-0.13%	11.83%	-0.38%	-$167,292	-0.13%	Imp	-7.06%	Yes	0.25%	$321,715	0.12%	$154,423
210051	DOCTORS	$141,094,311	-9.17%	0.73%	10.88%	-0.06%	$1,029,988	0.73%	Imp	11.59%	Yes	0.0%	$0	0.73%	$1,029,988
210056	MS-GOOD SAMARITAN	$146,901,579	-6.93%	0.51%	12.98%	-0.76%	$749,198	0.51%	Imp	-20.37%	Yes	0.5%	$734,508	1.01%	$1,483,706
210057	SHADY GR	$251,748,234	-8.49%	0.66%	10.09%	0.21%	$1,661,538	0.66%	Imp	-16.74%	Yes	0.5%	$1,258,741	1.16%	$2,920,279
210058	UMROI	$72,350,285	31.86%	-2.00%	11.30%	-0.20%	-$23,152	-0.03%	Att	7.57%	No	0.00%	$0	-0.03%	-$23,152

210060	FT. WASH	$19,890,383	11.19%	-1.21%	14.10%	-1.14%	-$226,750	-1.14%	Att	-19.73%	No	0.00 %	$0	-1.14%	-$226,750
210061	ATLANTIC GENERAL	$36,931,910	-5.31%	0.36%	10.01%	0.23%	$132,955	0.36%	Imp	-10.59%	Yes	0.50 %	$184,660	0.86%	$317,615
210062	MS-SO MD	$162,087,856	4.01%	-0.53%	13.02%	-0.78%	-$859,066	-0.53%	Imp	9.33%	No	0.00 %	$0	-0.53%	-$859,066
210063	UM ST. JOE	$223,399,907	-0.44%	-0.11%	11.48%	-0.26%	-$245,740	-0.11%	Imp	32.73%	Yes	0.00 %	$0	-0.11%	-$245,740
210064	LEVINDALE	$57,510,719	-8.68%	0.68%	10.00%	0.24%	$391,073	0.68%	Imp	-31.28%	Yes	0.50 %	$287,554	1.18%	$678,627
210065	HC GTOWN	$59,062,315	-5.79%	0.40%	11.90%	-0.40%	$236,249	0.40%	Imp	13.92%	Yes	0.00 %	$0	0.40%	$236,249
STATEWIDE		**$9,685,539,404**		**Net Reward/Penalty**			**$13,947,627**						**$20,288,666**		**$34,236,293**
Penalty				Penalty			-$7,891,071						$0		-$7,478,827
Reward				Reward			$21,838,698						$20,288,666		$41,715,120

Values for PG hospital represent just PG Hospital

Percentages have been rounded for display. Final scaling values are rounded to two decimal places.

maryland
health services
cost review commission

Draft Guidelines for Hospital Payment Plans, per Chapter 770 of 2021

April 13, 2022

This document contains the draft guidelines hospital payment plan required by Health General § 19-214(e)(3), Maryland Code ; comments on the draft may be submitted to Hannah Friedman-Bell (hannah.friedman-bell@maryland.gov) and are due Wednesday, April 20, 2022.

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

maryland
health services
cost review commission

Table of Contents

maryland
health services
cost review commission

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
Md. Code Health General §19-214 requires that hospitals provide financial assistance to low-income patients and follow rules around medical debt collection that are designed to protect patients. In 2021, the legislature changed the medical debt requirements, including a requirement that HSCRC develop guidelines for hospitals that require that payment plans be income based (Chapter 770, 2021).	The draft hospital payment plan guidelines meet the requirements of the statute. These guidelines were developed with input from a stakeholder workgroup.	Hospitals must follow these guidelines for any patient payment plans. These guidelines will likely cause some payment plans to have longer durations, which may negatively impact the amount collected. In addition, hospitals may need to update their online payment portals to meet the requirements of these guidelines. Those IT changes should be a one-time expense.	These guidelines provide additional protections for consumers, including by limiting the amount due under payment plans to five percent of the patient's income and prohibiting the collection of interest for patients who are eligible for financial assistance, in addition to providing other protections for patients.	To the extent that income-based payment plans are most beneficial to lower-income patients, this policy will help improve equity for this group, which includes a disproportionate share of racial and ethnic minorities.

Commission Action

Staff are presenting the draft "Guidelines for Hospital Payment Plans", in order to meet the requirements of Chapter 770 of 2021, Maryland Code. The draft guidelines are in Appendix I. A detailed explanation for each guideline is in Appendix II. These guidelines will be incorporated by reference into COMAR 10.37.10.26. Written comments on the draft guidelines will be accepted by the public through April 20, 2022. Final guidelines will be presented for approval at the May monthly Commission meeting.

Introduction

Since 2009, Maryland law has required each hospital to have a policy on the collection of debts owed by patients (Health General §19-214.2, Maryland Code). This law contains protections for patients (including the prohibition of interest on certain debt owed by self-pay patients, a prohibition on hospitals selling debt,

and a requirement that the hospital's policy clearly describe the hospital's procedures for collecting a debt).[1] Chapter 770 of 2021 made a number of statutory changes to Health General §19-214, Maryland Code, related to hospital collection of medical debt, including adding a requirement that hospital payment plans for patients must meet guidelines developed by the Commission. Chapter 770 required that the HSCRC seek input from stakeholders in drafting these guidelines. Accordingly, the HSCRC formed a Workgroup on Hospital Payment Plan Guidelines, which met three times between January and February of 2022 to review guidelines originally drafted by HSCRC staff, in collaboration with staff from the Office of the Commissioner of Financial Regulation (OCFR).[2] Workgroup members and members of the public were also invited to submit written comments on the draft guidelines.

HSCRC and OCFR staff revised the guidelines based on feedback from the workgroup and members of the public. HSCRC staff are working on additional documents to provide further guidance for hospitals on implementation of Chapter 770, including updates to COMAR 10.37.10.26 and a Frequently Asked Questions document, which is being developed in conjunction with OCFR. In addition, HSCRC staff plan to update the Special Audit Procedures to reflect the new requirements in Chapter 770.

Background

Chapter 770 of 2021

In addition to updating hospital debt collection requirements under Health General §19-214, Chapter 770 of 2021 required HSCRC to develop guidelines for hospital income-based payment plans with input from stakeholders. Chapter 770 requires that these guidelines include:

(1) the amount of medical debt owed to the hospital;

(2) the duration of the payment plan based on a patient's annual gross income;

(3) guidelines for requiring appropriate documentation of income level;

(4) guidelines for the payment amount, that:

(i) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income; and

(ii) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article;

(5) guidelines for:

[1] Maryland law also requires that hospital provide financial assistance to lower income patients (Health General §19-214.1, Maryland Code).

[2] OCFR is Maryland's consumer financial protection agency and financial services regulator. Among other things, the Office is responsible for licensing and supervising state-licensed financial institutions including consumer debt collection agencies, consumer lenders, installment lenders, credit services businesses, debt management companies to ensure compliance with the laws and regulations of Maryland.

(i) the determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 180 days after the due date of the first payment; and

(ii) a prohibition on interest payments for patients who qualify for free or reduced–cost care;

(6) guidelines for modification of a repayment plan that does not create a greater financial burden on the patient; and

(7) a prohibition on penalties or fees for prepayment or early payment.

Chapter 770 required that, in drafting the income-based payment plan guidelines, HSCRC seek input from stakeholders, including the Maryland Hospital Association, Maryland Insurance Administration, Office of the Attorney General, labor unions that represent the health care sector, a statewide nonprofit consumer rights group; patients' rights organizations, legal service providers who work with patients who have experienced medical debt; and patients who have experienced medical debt.

Hospitals must demonstrate that they attempted in good faith to meet the requirements of the guidelines before either filing an action to collect a debt owed on a hospital bill by a patient or delegating collection activity to a debt collector for a debt owed on a hospital bill by a patient.[3]

The effective date for Chapter 770 was January 1, 2022. On December 7, 2021, Kathryn Rowe, the Assistant Attorney General for the General Assembly, issued an opinion that the provision of Chapter 770 relating to the guidelines "could be given partial effect until such time as the guidelines are in place. All other provisions in the bill can be given full effect on the January 1, 2022, effective date".[4] Ms. Rowe further stated, "some of the provisions that have to be included in the hospitals' income-based payment plans are clearly stated in the law itself, even before the Commission has issued its final guidelines", so that hospitals could comply with those provisions until the Commission guidelines were in place.

Policy Goals

In developing these guidelines, HSCRC staff balanced a number of different policy goals. In general, HSCRC sought to focus on the requirements of Health General §19-214.2, as amended by Chapter 770 (2021). This contained the potential scope of the guidelines.

Under the law, income-based payment plans are now required for all patients, regardless of income. In developing these guidelines, HSCRC staff sought to balance providing protections to the low- and

[3] Health General §19–214.2 (e)(5), Maryland Code
[4] Kathyn M. Rowe, Letter to the Honorable Lorig Charkoudian regarding Chapter 770 of 2021, December 7, 2021.

moderate-income patients who will most benefit from these protections, while trying to minimize the burden on other patients.

HSCRC staff also worked to ensure that the guidelines provide patients with all the protections required by law while continuing to require that hospitals seek payment from patients who can pay their bills. This balance is intended to avoid unnecessary increases in uncompensated care costs.

Process for Soliciting Stakeholder Input

To meet the requirements in Chapter 770 of 2021 for developing the payment plan guidelines, HSCRC formed a Workgroup on Hospital Payment Plan Guidelines. This group reviewed a draft of the guidelines written by HSCRC staff in conjunction with staff from the Office of the Commissioner of Financial Regulation (OCFR). The workgroup met three times:

1. 6:30 – 8:30pm on Monday, January 24, 2022
2. 9:00 – 11:00am on Friday, February 11, 2022
3. 3:00 – 5:00pm on Monday, February 28, 2022

HSCRC publicized this workgroup on its website[5] and also sent workgroup notifications to a group of interested stakeholders. Each workgroup meeting included time for public comment from non-workgroup members. In addition to receiving input through workgroup discussion, HSCRC also asked workgroup members and other interested stakeholders to provide written comments. HSCRC staff considered both the verbal comments from workgroup discussion and the written comments received from stakeholders when writing the draft of the guidelines presented to the Commission. See Appendix III for the full list of workgroup members.

Additional Documents

In addition to the guidelines presented in this recommendation, HSCRC staff have been working on updates to regulations to align COMAR 10.27.10.26 with the changes made to Health General §19–214 under Chapter 770. This update to COMAR will incorporate the payment plan guidelines by reference. Staff expect to present those updates when the final payment plan guidelines are considered by Commissioners in May 2022.

HSCRC staff are also working with staff from OCFR on a “Frequently Asked Questions” document to provide additional clarity on Chapter 770 for hospitals and debt collectors.

Finally, HSCRC plans to update its Special Audit Procedures for FY2024 to ensure hospitals are complying with Chapter 770.

[5] See https://hscrc.maryland.gov/Pages/Workgroup-on-Hospital-Payment-Plan-Guidelines.aspx

Appendix I. Draft Guidelines for Hospital Payment Plans

1) **Definitions:**
   a) In these guidelines, the following terms have the meanings indicated.
   b) Terms defined.
      i) **Financial Hardship:** "Financial hardship" has the same meaning as in COMAR 10.37.10.26 §A-2.
      ii) **Written:** "Written" includes communications in paper form and communications delivered electronically, including through electronic mail and through a secure web or mobile based application such as a patient portal. "Written" does not include oral communications, including communications delivered by phone. A patient may opt out of electronic communications by informing the hospital or debt collector orally or through written communication.
2) **Scope:**
   a) These guidelines apply to any payment plans offered by hospitals to patients to pay for hospital services after the services are provided. These guidelines do not apply to arrangements to make payments prior to the provision of a hospital service.
   b) Nothing in these guidelines prevents a hospital from offering patients arrangements to make payments prior to service, provided that–
      i) A hospital may not require or steer a patient to enter into such an arrangement solely to avoid the application of these guidelines; and
      ii) Such an arrangement terminates once the hospital service is rendered.
3) **Access to Payment Plans:**
   a) **Available to all Maryland Residents:** Maryland hospitals must make payment plans available to all patients who are Maryland residents, including people temporarily residing in Maryland due to work or school, irrespective of their:
      i) Insurance status;
      ii) Citizenship status;
      iii) Immigration status; or
      iv) Eligibility for reduced cost care, including reduced cost care due to financial hardship, under COMAR 10.37.10.26 §A-2(2)(a)(ii) and §A-2(3).
   b) **Treatment of Non-Residents:** These guidelines do not prevent hospitals from extending payment plans to patients who are not described in subsection (a). Except as otherwise required by law or regulation, payment plans for patients who are not described in subsection (a) are not subject to these guidelines.

4) **Notice Requirements:**
   a) **Notice of Availability of Payment Plans***:* A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of the availability of a payment plan and whom to contact at the hospital for additional information.
   b) **Notice of Terms before Execution:** Hospitals shall provide notice of the terms of a payment plan to a patient before the patient agrees to enter the payment plan. The terms of the payment plan must include:
      i) The amount of medical debt owed to the hospital;
      ii) The amount of each periodic payment expected from the patient under the payment plan;
      iii) The number of periodic payments expected from the patient under the payment plan.
      iv) The expected due dates for each payment from the patient;
      v) The expected date by which the account will be paid off in full;
      vi) The treatment of any missed payments (including missed payments under guideline 10) and default; and
      vii) If the hospital plans to apply a periodic recalculation of monthly payment amounts under guideline 9(c), the process for such recalculation.
   c) **Notice of Plan after Execution:** A hospital shall promptly provide a written payment plan, including items listed in subsection (b), to the patient following execution by all parties. The payment plan shall be provided to the patient at least 10 days before the due date of the patient's first payment under the payment plan.
5) **Payment plans are income-based:**
   a) **Financial assistance:** Before entering a payment plan with a patient, a hospital shall evaluate if the patient is eligible for financial assistance (including free care, reduced-cost care, and reduced-cost care due to financial hardship) in accordance with COMAR 10.37.10.26 §A-2.
   b) **Monthly payment amounts are limited to 5% of income:** Under a payment plan subject to these guidelines, a hospital shall not require a patient to make total payments in a month that exceed 5% of the lessor of the individual patient's federal or State adjusted gross monthly income. This applies to total amounts due under the plan, including both principal and interest.
   c) **Calculation of income:** A hospital shall calculate a patient's income by taking the following steps:
      i) **Determining the income amount:** Determining the lessor of the patient's federal or state adjusted gross income. If the patient has not provided their tax returns, the hospital shall use available information, including information provided by the patient, to approximate the patient's adjusted gross income. Income that is not taxable, such as certain gifts, should not be treated as income for purposes of determining the income limitation under this guideline.
      ii) **Determining the number of filers and dependents:** The hospital shall determine the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a

married couple files jointly and has three dependents, the number of tax filers and dependents would equal five. If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one. If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of tax filers and dependents.

iii) **Determining the patient's pro-rata share of income:** The hospital shall divide the income amount determined under paragraph (i) by the number of tax filers and dependents under paragraph (ii). This is the individual patient's income for purposes of determining the 5% limit on the income-based payment plans under these guidelines.

d) **Income documentation:**

i) Hospitals shall accept generally acceptable forms of documentation that verify income, such as tax returns, pay stubs, and W2s.

ii) Hospitals may accept patient attestation of the patient's monthly or annual income without documentation. Such an attestation must include the patient's income and the number of filers and dependents on their tax return.

e) **Expenses:** A hospital shall consider information provided by a patient about household expenses in determining the amount of the monthly payment due under a payment plan.

f) **Application to multiple payment plans:**

i) **Hospitals:** A hospital must ensure that the total monthly payment amount for all payment plans provided to a patient by such hospital, when added up collectively, may not exceed the income limitation under subsection (b).

ii) **Hospital system:** A hospital system must ensure that the total monthly payment amount for all payment plans provided to a patient by all hospitals in the hospital system, when added up collectively, may not exceed the income limitation under subsection (b).

6) **Duration of payment plan:** The duration of a payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5% of the patients income as calculated under guideline (5).

7) **Interest and fees:**

a) **No interest for patients eligible for charity care:** A hospital shall not charge and collect interest on the medical debt amount owed under a payment plan for patients who qualify for free or reduced-cost care, including reduced cost care due to financial hardship, under COMAR 10.37.10.26 §A-2(2)(a) and §A-2(3).

b) **No Interest for self-pay patients:** A hospital may not charge interest on bills incurred by self-pay patients in a payment plan.

c) **Interest allowed:** A hospital may charge interest under a payment plan for a patient who is not described in subsection (a) or (b). A hospital is not required to charge interest for a payment plan.

d) **Interest rate.** A payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan. A hospital may not set an interest rate that results in negative amortization.

e) **Timing:** Interest may not begin before 180 days after the due date of the first payment.

f) **Late payments:** A hospital may not charge additional fees or interest for late payments.

8) **Early payment:**

a) **Prepayment allowed:** Patients may, on a voluntary basis, pre-pay, in whole or in part, any amounts owed under a payment plan. Any prepayment made under this provision is not subject to guideline (5)(b).

b) **No fees or penalties:** A hospital shall not assess fees or otherwise penalize early payment of a payment plan provided by a patient.

c) **Solicitation of early payments prohibited:** Hospitals may not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in a payment plan.

9) **Limited Modifications of Payment Plans and Recalculations of Payment Amounts:**

a) **Limitations on payment plan modifications:** A hospital may only modify a payment plan in the following ways:

i) **Limitation on payment amount:** A hospital shall not modify a payment plan in a way that requires a patient to make a monthly payment that exceeds the percent of the patient's income used to set the monthly payment amount under the initial payment plan as provided for in guideline (5).

ii) **No increase in interest rate:** A hospital may not increase the interest rate on a payment plan when making a modification under this guideline.

iii) **Change in duration:** The duration of a modified payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitations under guideline (5) and section (d) of this guideline.

b) **Process for modifying a payment plan:**

i) **Prompt response to patient request:** If a patient requests a modification to the terms of the payment plan, the hospital must respond in a timely manner and may not not refer the outstanding balance owed to a collection agency or for legal action until 30 days after providing a written response to the patient's request for a modification of the payment plan.

ii) **Reconsideration for financial assistance:** If a patient makes a request for modification of a payment plan, the hospital shall consider if such patient is eligible for financial assistance (including free care, reduced-cost care, and reduced-cost care due to financial hardship under COMAR 10.37.10.26 §A-2(2)(a) and §A-2(3)).

iii) **Change in income:** If a patient notifies a hospital that the patient's income has decreased, as calculated under guideline (5), then the hospital shall offer to modify the payment plan to meet the requirement of subsection (a)(i) of this guideline.

iv) **Expenses:** A hospital shall consider information provided by a patient about changes in household expenses in considering a patient request to modify a payment plan.

v) **Mutual agreement:** A hospital shall not modify a payment plan without mutual agreement between the hospital and the patient before the changes are made.

vi) **Notice of terms:** The hospital must provide the patient with a written notice of all payment plan terms, consistent with the requirements of guideline (4), upon modifying a payment plan under this guideline.

c) **Hospital-initiated changes to payment plans based on changes to patient income:**

i) **Recalculation allowed:** A hospital may, in the terms of an initial payment plan that exceeds 3 years in length, provide for periodic recalculations to the amount of the monthly payments and the duration of the payment plan based on changes in the patient's income as subject to and calculated under guideline (5).

ii) **Term included in initial payment plan:** The patient's agreement to the initial terms of the payment plan constitutes consent to the payment recalculations allowed under this subsection if the hospital included the term in the initial payment plan per guideline 4(b)(vii).

iii) **Limitations on modification apply:** Subsection (a) and paragraphs (i), (ii), (iii), (iv), and (vi) of subsection (b) apply to payment recalculations under this subsection.

iv) **Frequency of recalculation:** A hospital may not seek a recalculation of the monthly payment amount, as provided for under this subsection more often than once every 3 years.

v) **Treatment of missing information:** If a patient does not provide income information on the request of the hospital seeking to make a change to a payment plan under this subsection and the patient is in good standing on the patient's payments under the payment plan the hospital shall not change the monthly payment amounts under the payment plan.

10) **Treatment of missed payments:**

a) **First Missed Payment:**

i) A hospital may not deem a patient to be noncompliant with a payment plan if the patient makes at least 11 scheduled monthly payments within a 12-month period.

ii) The hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments.

iii) The hospital may consider a patient to be in default on the payment plan if the missed payment is not repaid in full by the end of the 12-month period that begins on the date of the missed payment under paragraph (i).

b) **Additional missed payments:**

i) A hospital may forbear the amount of any additional missed payments that occur in a 12-month period.

ii) If a hospital forbears the amount of any additional missed payments that occurs in a 12-month period, the hospital shall allow the patient to continue to participate in the income-based payment plan.

iii) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital may not refer the outstanding balance owed to a collection agency or for legal action.

iv) The hospital shall recapitalize the amount of any missed payments that were subject to forbearance under this subsection as additional payments at the end of the payment plan, thereby extending the length of the payment plan.

v) The hospital shall provide written notice to the patient of the treatment of the missed payments, including any extension of the length of the payment plan.

11) **Treatment of loans and extension of credit:**

a) After a hospital service is provided to the patient, a hospital may not make any loan or extension of credit to the patient that is inconsistent with these guidelines for medical debt resulting from that service.

b) A hospital may not partner with a third party to make a loan or extension of credit that is–

i) Offered to the patient after hospital services are provided to the patient for debt incurred due to those hospital services; and

ii) Inconsistent with these guidelines.

12) **Debt Collectors:** Hospitals shall require that debt collectors operating under contract with the hospital abide by the requirements of these guidelines.

13) **Application of Credit Provisions of Maryland Commercial Code:** A payment plan is an extension of credit subject to Maryland credit regulations under the Annotated Code of Maryland, Commercial Law Article, Title 12. Accordingly, hospitals must elect or otherwise enter into an income-based payment plan under one of the subtitles thereunder. Pursuant to CL § 11-302(b)(6), if a hospital is making an extension of credit through a payment plan for hospital services rendered under Subtitles 1, 9, or 10 of the Commercial Law Article, and is otherwise not making loans or acting as a loan broker, then an Installment License issued by the Commissioner of Financial Regulation may not be required to engage in such activity.

14) **Books and Records:** A hospital must retain books and records on payment plans for at least 3 years after the payment plan is closed.

15) **Default:** If a patient defaults on a payment plan and the parties are not able to agree to a modification, then the hospital must follow the provisions of its collection and write-off policy for the collection of debt established in accordance with COMAR 10.37.10.26 §A-1, before a hospital may write this debt off as bad debt.

Appendix II: Staff Explanation for Guidelines for Hospital Payment Plans

This appendix includes the HSCRC staff explanation for the content of the draft hospital payment plan guidelines. HSCRC staff considered input from a variety of stakeholders while developing the hospital payment plan guidelines. This included discussion from workgroup meetings, as well as written comments submitted by workgroup members and other stakeholders as a part of the workgroup process.

Guideline (1) "Definitions": This guideline provides definitions for terms used in these guidelines.

> **Guideline (1)(b)(i) "Financial hardship":** This defined term is to clarify that the definition of financial hardship in these guidelines is the same as the definition of financial hardship in Health General §19-214.1.
>
> **Guideline (1)(b)(ii) "Written":** The purpose of this term is to clarify that notices required under these guidelines may be delivered by paper or electronically but may not be delivered orally. In addition, patients may opt out of electronic communication.
>
> Stakeholders discussed what the minimum standard for notice should be given the many different technologies that may be used (including paper documents, web-based portals, apps, the phone, etc.). Staff believe that notices required in these guidelines must be provided in writing, either electronically or on paper.

Guideline (2) "Scope": The purpose of this guideline is to clarify that these guidelines do not apply to pre-payment plans or other arrangements for payments where the payment occurs before the hospital service is provided.

A stakeholder advocated for including pre-payment plans under these guidelines. In developing these guidelines, HSCRC focused on the requirements of Health General §19-214.2, as amended by Chapter 770 (2021). Health General §19-214.2 addresses medical debt and debt collection and does not address arrangements for payments prior to the provision of a hospital service. Payments for a medical service before the service is provided are not a form of medical debt. In addition, some of the elements of the guidelines that are required by Health General §19-214.2 would not be appropriate for pre-payment plans. For example, a provision allowing interest for prepayment plans would not be appropriate, as prepayment is not a form of debt.

Staff added guideline (2)(b) to clarify that arrangements to make payments before a service is provided may not be used to avoid the requirements of these guidelines, and that those arrangements terminate when

hospital services are provided. This ensures that these guidelines apply to payment plans after the date of service.

Guideline (3) "Access to payment plans": HSCRC staff determined that the payment plan guidelines should apply to all Maryland residents to be consistent with debt collection law in the State and the jurisdiction of the courts over outstanding debt. The stakeholders agreed that these guidelines should not be limited by the hospital's service area, but rather should apply to all Maryland residents. Hospitals should interpret the concept of a Maryland resident broadly to include individuals in Maryland for school or work, including members of the armed services stationed in Maryland. Staff believe that payment plans should be available to patients regardless of insurance status, immigration status, or eligibility for hospital reduced cost care. Some of the listed items (for example, immigration status) are also included in hospital financial assistance law under Health General §19-214.1.

Hospitals may provide payment plans to residents of other states and countries, including self-pay patients from other countries who come to Maryland specifically for medical treatment ("medical tourists"), but those payment plans are not subject to these guidelines.

Guideline (4) "Notice Requirements":

> **Guideline (4)(a) "Notice of Availability of Payment Plans":** Stakeholders discussed whether notice of the availability of payment plans should be posted in hospitals, similar to the notices related to financial assistance which are required under COMAR 10.37.10.26 A-2. HSCRC staff included this requirement in these guidelines.
>
> **Guideline 4(b) Notice of Terms before Execution:** The purpose of this guideline is to ensure that patients receive clear notice of the terms of any hospital payment plan before they agree to the payment plan. Health General §19-214.2(e)(3), as amended by Chapter 770, 2021, requires notice of the amount of medical debt owed to the hospital and the duration of the payment plan based on the patient's gross annual income. This guideline adds additional required information to this notice to ensure transparency for consumers and to align with best practices for other forms of commercial debt.
>
> **Guideline (4)(c) "Notice of Plan after Execution":** The purpose of this guideline is to ensure that patients receive clear notice of the terms of any hospital payment plan once it is agreed to by both parties. Stakeholders discussed the time period between when the notice is provided and when the first payment is due. Staff decided that 10 days was an appropriate time.
>
> A prior version of these guidelines included language including notice of the availability of payment plans in the information sheet required by COMAR 10.37.10.26. This text has been moved into the

revisions to COMAR 10.37.10.26 and removed from these guidelines (which will be incorporated, by reference, into COMAR 10.37.10.26).

Guideline (5) "Payment plans are income-based": Health General §19-214.2(e)(3), as amended by Chapter 770, 2021, states that the "Commission shall develop guidelines … for an income-based payment plan". This guideline addresses that requirement.

Guideline (5)(a) "Financial Assistance": Health General §19-214.2(e)(3), as amended by Chapter 770, 2021, requires that guidelines for the payment amount "shall consider financial hardship, as defined in" Health General § 19–214.1(a). Stakeholders interpreted this language as relating to determinations of financial assistance. This guideline clarifies that hospitals should consider patients for financial assistance, including reduced-cost care due to financial hardship, before entering a payment plan with the patient.

Guideline (5)(b) "Monthly amounts due limited to 5% of income": Health General §19-214.2(e)(3), as amended by Chapter 770, 2021, states that the payment amount under the payment plan "may not exceed 5% of the individual patient's federal or State adjusted gross monthly income". This guideline reflects the statutory requirement. This guideline sets a cap on monthly payment amounts. A hospital may enter into a payment plan with monthly payments that are less than 5% of the patient's income.

Guideline (5)(c) "Calculation of income": The income-limitation on payment plans under Health General §19-214.2(e)(3), as amended by Chapter 770, 2021, is tied to " the individual patient's federal or State adjusted gross monthly income."

Stakeholders discussed the meaning of "adjusted gross income", as it is used in Health General §19-214.2(e)(3). Under Federal tax law, adjusted income is total income minus adjustments. Adjustments to income include such items as education expenses, student loan interest, alimony payments, and contributions to a retirement account. Medical expenses are a deduction (not an adjustment) and thus are not a factor in determining adjusted gross income.

The meaning of "individual patient" was discussed in the workgroup and in a number of written comments. Staff had two concerns about the use of individual income to determine the income limitation for hospital payment plans. The first concern is that, to the extent that "adjusted gross income" is a tax law term, it would be difficult to determine individual adjusted gross incomes for individuals who do not file individually, but rather file jointly or are dependents of tax filers. Second, the use of individual income could result in unintended outcomes. For example, a non-working spouse or child in a high income household could have an individual income of zero dollars, resulting in an income repayment plan with monthly payments that cannot exceed $0, despite that

household's ability to pay for hospital charges. Conversely, a sole wage owner in a family with many dependents would end up with a higher payment plan income limit if their dependents were not taken into account. Several approaches were suggested to staff to address this issue. Ultimately, staff decided that using a pro-rata share of the adjusted gross income for all filers and dependents was the best approach.

Guideline (5)(d) "Income documentation": Health General §19-214.2(e)(3), as amended by Chapter 770, 2021, requires "guidelines for requiring appropriate documentation of income level" for payment plans. Prior to 2021, hospitals were not required to use income criteria for patient payment plans. In comments, some stakeholders expressed concerns that any requirements related to income disclosures or documentation may discourage patients who do not want to provide that information from entering into a payment plan, potentially decreasing the use of payment plans. Other stakeholders were focused on ensuring that hospitals receive some form of income documentation for all payment plans due to the belief that this conforms with the intent of the law. HSCRC staff interpret the law as requiring hospitals to determine an individual's income. Given the law's use of adjusted gross income, the tax form is the best source of income documentation for this law. However, staff agree that flexibility in what form of documentation hospitals use, including use of self-attestation, is appropriate to encourage use of payment plans.

Some stakeholders requested that the guidelines allow hospitals to request patient attestations that the payment plan is under 5% of income (for example, through a check box and signature) rather than collecting income information from the patient. HSCRC staff do not think this approach satisfies the legal requirement that payment plans be income-based. Hospitals may not accept such an attestation in lieu of collecting information about the patient's income and calculating the 5% limitation on the monthly payment amount based on the income information provided by the patient.

Guideline (5)(e) "Expenses": Stakeholders noted that household expenses may affect a patient's ability to pay back medical debt under a payment plan. The only expense implicitly addressed in the law was medical debt that meets the definition of financial hardship (this topic is addressed in guideline (5)(a)). Staff want to encourage hospitals to consider patient circumstances.

Guideline (5)(f) "Application to multiple payment plans": This provision is to clarify that each hospital may not apply the 5% income limitation independently to multiple payment plans for the same patient. The 5% income limitation applies to the total monthly amount due from a patient across all medical debt owed to a hospital. and to a hospital system. The same rule applies to hospital systems. In other words each hospital and hospital system must ensure that the total

monthly amount due from a patient under all payment plans within a hospital and across the hospital system (if applicable) does not exceed the 5% income limitation on payment plans.

Some workgroup members wanted coordination between all hospitals and hospital systems in the State. This would ensure that patients did not have monthly payments for hospital debt that exceeded 5% of their income, regardless of how many hospital(s) the patient had payment plans with. HSCRC staff determined that operationalizing such an approach was not operationally feasible at this time.

Guideline (6) "Duration of payment plan": Under Health General §19-214.2(e)(3), HSCRC must include a guideline related to the "duration of the payment plan based on the patient's annual gross income." This guideline clarifies that a hospital must take into account the requirement that monthly payments may not exceed 5% of the patient's income when determining the duration of a payment plan.

Guideline (7) "Interest": Under Health General §19-214.2(e)(3), the guidelines must include "a determination of possible interest payments for patients who do not qualify for free or reduced cost-care". Guideline (7) is designed to meet that regulatory requirement.

Guideline (7)(a) "No interest for patients eligible for charity care": Health General §19-214.2(e)(3) prohibits the application of interest payments for patients who qualify for free or reduced-cost care. This guideline restates this requirement.

Guideline (7)(b) "No Interest for self-pay patients": Health General §19-214.2(b)(3) prohibits the charging of interest on bills incurred by self-pay patients before a court judgment is obtained. This guideline restates this requirement and clarifies its application to payment plans.

Guideline (7)(c) "Interest allowed": Stakeholders debated whether interest should be prohibited for all patients. Hospitals state that, as of early 2022, they are not applying interest to payment plans. HSCRC staff determined that the law requires HSCRC to develop a guideline that allows, but does not require, interest to be charged.

Guideline (7)(d) "Interest Rate": This guideline sets an interest rate cap of a 6% annual percentage rate. This is the constitutional rate of interest in Maryland, and is half of the interest rate cap that HSCRC applies to hospital accounts receivable under COMAR 10.37.10.26 (B)(3). Article 3, §57 of the Maryland Constitution states that "the legal rate of interest shall be six per cent per annum; unless otherwise provided by the General Assembly ".

Staff decided to use a flat interest rate cap to create certainty for patients entering a payment plan, both with respect to the amount of monthly payments due under the payment plan and the length of the payment plan.

Staff and stakeholders considered other amounts for the interest rate cap, including the following:

- A flat cap of 5% APR.
- The hospital annual update factor, which varies annually, but is normally between 3-4% a year. Growth in the update factor is constrained by Maryland's agreements with the federal government to achieve Medicare savings under the Total Cost of Care agreement.
- The interest rate caps that apply to consumer financing under Consumer Law § 12-1003 (24% per year).
- The interest rate cap for judgements (10%).

Some stakeholders expressed a preference for tying the interest rate cap in these guidelines to an interest rate cap that exists elsewhere in Maryland law. The decision to use the Constitutional interest rate accomplishes this goal. Staff rejected the interest rate cap under Consumer Law § 12-1003 as too high for the purpose of financing health care, a necessary expenditure. Staff also felt that choosing an interest rate that was lower than the interest rate on judgments made sense, since judgements occur when a patient has failed to pay medical debt, and a patient who is making timely payments on a payment plan is compliant with their obligations to pay their debt.

Guideline (7)(e) "Timing": Health General §19-214.2(e)(3) states that interest payments on payment plans "may not begin before 180 days after the due date of the first payment" under the payment plan. This guideline restates this requirement.

Guideline (7)(f) "Late payments": This guideline prohibits hospitals from charging additional fees or interest for late payments. The purpose of this guideline is to ensure that monthly payments remain below the income limitation under guideline (5) and are consistent with provisions of Health General §19-214.2 related to the treatment of missed payments, as addressed in guideline (10).

Guideline (8) "Early payment": Under Health General §19-214.2(e)(3), the guidelines must prohibit "penalties or fees for prepayment or early payment." This guideline restates that requirement and clarifies hospitals' obligations around patients who voluntarily make prepayments on payment plans. A hospital shall consider any voluntary payment that a patient makes in excess of the monthly payment amount under the payment plan to be a prepayment on the payment plan. Voluntary prepayments may exceed the 5% income limitation on payment amounts under guideline (5). Hospitals may not, in any manner, direct a patient to pay more than the monthly payment amount under the payment plan.

Guideline (9) "Limited Modifications of Payment Plans and Recalculations of Payment Amounts": Health General §19-214.2(e)(3) contains several requirements related to modification of payment plans.

Guideline (9)(a) "Limitations on payment plan modifications": This subsection states the ways in which a hospital may modify a payment plan. No other types of modifications are permitted.

Guideline (9)(a)(i) "Limitation on payment amount": Health General §19-214.2(e)(3) requires that HSCRC include "guidelines for modification of a payment plan that does not create a greater financial burden on the patient." HSCRC staff expect that patient income may change over the course of the payment plans. This guideline allows for an upward or downward adjustment in the monthly payment amount if the patient's income increased or decreased since the start of the payment plan, but it does not allow for a change in the percent of income charged monthly under the payment plan. For example, if the monthly payments under the original plan were set at 4% of monthly income, the payments under the modified plan must not exceed 4% of the patient's new monthly income.

Guideline (9)(a)(ii) "No change in interest rate": This guideline prevents a hospital from increasing the interest rate on a payment plan when modifying a payment plan. This responds to stakeholders who wanted to make sure that patients had certainty about interest rates for the full duration of their payment plans.

Guideline (9)(a)(iii) "Change in duration": This provision clarifies how modifications to the payment plan impact the duration of the payment plan.

Guideline (9)(b) "Process for modifying a payment plan": This subsection details the procedural requirements that hospitals must follow to modify a payment plan.

Guideline (9)(b)(i) "Prompt response to patient request": This guideline is designed to ensure that hospitals respond promptly to patient requests for a modification to a payment plan. This guideline also ensures that patients who have made such a request to a hospital are not referred to collections or legal action until after the patient has received notice of the hospital's decision.

Stakeholders differed in what amount of time was needed before referral to collections or legal action, with a range from 30 to 180 days. Staff decided that 30 days was appropriate given the many other protections against referral for collections or legal action in Health General §19-214.2.

Guideline (9)(b)(ii) Reconsideration for financial assistance": This ensures that patients who request a modification to their payment plan are considered for financial assistance. For example, if a patient requests a reduction in the monthly payment amount because the patient cannot afford the monthly payment amount, the hospital is required to consider if the patient is eligible for financial assistance.

Guideline (9)(b)(iii) "Change in Income": This guideline requires hospitals to take action to modify a payment plan if the patient informs the hospital that their income has decreased.

Guideline (9)(b)(iv) "Expenses": This guideline treats household expenses in the same manner for the purpose of modifying a payment plan that these expenses are treated for determining the monthly payment amounts under the original terms of a payment plan under guideline (5).

(9)(b)(v) "Mutual Agreement": Health General §19-214.2(b)(10) requires hospitals provide a mechanism to allow "the patient and the hospital to mutually agree to modify the terms of a payment plan offered …or entered into with the patient." This guideline restates that requirement.

Guideline (9)(b)(vi) "Notice of terms": This provision clarifies that hospitals must provide the patient with notice of the modified payment plan terms.

Guideline (9)(c) "Hospital-initiated changes to payment plans based on changes to patient income": This guideline allows hospitals to change a payment plan every three years based on changes in patient income. HSCRC staff believe it is important for hospitals to have the option to change payment plans based on changes in patient income, given that staff expect that payment plans will be longer under this new regulatory regime than they have been in the past. For example, if a newly independent young adult incurs significant medical costs, which take many years to repay, it is very likely that the patient can afford higher payments as their career progresses. Conversely, a patient's income may have declined, and this provides an opportunity for the hospital to proactively reduce the monthly payment for the patient. In response to stakeholder comments, HSCRC staff drafted this provision to give hospitals the flexibility to change the payment amount payment plan based on income, but hospitals are not required to recalculate payment amounts under this subsection. HSCRC staff also added patient protections to this provision, including that payment plans continue under the prior terms if a patient does not respond to the hospital's request for income information.

Guideline (10) "Treatment of missed payments":

Guideline (10)(a) "First Missed Payment": Health General §19-214.2(e)(4) states that "a patient shall be deemed to be compliant with a payment plan if the patient makes at least 11 scheduled monthly payments within a 12-month period." This provision simply restates this statutory requirement and provides clarification of hospital responsibilities related to payment plans when a patient misses a monthly payment.

Guideline (10)(b) "Additional missed payments": Health General §19-214.2(e)(4) states that "The health care facility may, but may not be required to, waive any additional missed payments that occur within a 12-month period and allow the patient to continue to participate in the income-based payment plan and not refer the outstanding balance owed to a collection agency or for legal action." This provision clarifies that a hospital shall forbear these payments if the hospital chooses to allow additional missed payments and recapitalize these payments at the end of the payment plan. This provision also clarifies the hospital's obligations if the hospital forbears additional missed payments, including a requirement to provide notice to the patient of the treatment of missed payments.

A prior version of guideline (10) included a provision related to termination of payment plans. Based on stakeholder feedback, HSCRC staff removed that provision from these guidelines and removed references to "termination" of payment plans from these guidelines.

Guideline (11) "Treatment of Loans and extension of credit": Some hospitals provide loans in addition to or instead of payment plans, either directly or through an agreement with a third party. This guideline is intended to clarify that these guidelines apply to loans in the same manner that they apply to payment plans. This ensures that hospitals comply with these guidelines regardless of the type of arrangement (payment plan, loan, other extension of credit) that exists between the hospital and the patient.

HSCRC does not intend these guidelines to apply to loans or other forms of consumer credit (such as credit cards) that are offered to patients by entities that do not have an agreement with the hospital. These forms of credit are outside of the scope of Health General §19-214.2 and are subject to Federal and State law related to consumer protection for financial products.

Guideline (12) "Debt Collectors": Health General §19-214.2(b)(1) requires that hospitals provide "active oversight…of any contract for collection of debts on behalf of the hospital." In addition, Health General §19-214.2(k) specifies that hospitals that use debt collectors must "require the debt collector to abide by the hospital's credit and collection policy," and that debt collectors "along with the hospital, be jointly and severally responsible for meeting the requirements of" Health General §19-214.2. The purpose of this guideline is to clarify that a hospital must ensure that their debt collector partners follow these guidelines, which are required by Health General §19-214.2.

Guideline (13) "Application of Credit Provisions of Maryland Commercial Code": The purpose of this guideline is to ensure that all hospitals are on notice that the credit provisions of the Maryland Commercial Code apply to payment plans. This does not reflect a change in law.

Guideline (14) "Books and Records": This guideline is intended to set a minimum document retention period for documents related to payment plans. Three years after a payment plan ends is sufficient time for

the purposes of HSCRC's audit requirements and for compliance activities. We considered other books and records requirements, including requirements under the Health Insurance Portability and Accountability Act, the Regulation F from the Federal Consumer Protection Bureau, and the Maryland Commercial Code. Hospitals reported that they routinely retain records for 7 years after the date of service if the case is closed or 5 years after the last cost report. This guideline does not change any Federal or State laws related to document retention that may apply to these documents.

Guideline (15) "Default": This guideline restates existing HSCRC policy that a hospital must follow its collection and write-off policy when collecting medical debt, including defaults on a payment plan, before writing a debt off as bad debt. Hospital collection and write-off policies are subject to a number of requirements under Health General §19-214.2 and COMAR 10.37.10.26 §A-1.

Staff reworded this guideline to address stakeholder concerns that an earlier version of this guideline implied that hospitals could pressure patients into paying more than the 5% allowed under Guideline (5) or solicit prepayments.

Appendix III: Workgroup Members

1. Brett McCone, *Maryland Hospital Association*
2. Lakmini Kidder, *Johns Hopkins Health System*
3. Mark Norby, *University of Maryland Medical System*
4. Sue Whitecotton, *Medstar Health*
5. Cheryl Nottingham, *Atlantic General Hospital*
6. Bradley Boban, *Maryland Insurance Administration*
7. Pat O'Connor, *Health Education and Advocacy Unit of the Maryland Attorney General's Office*
8. Girume Ashenafi, *1199SEIU United Healthcare Workers East*
9. Marceline White, *Maryland Consumer Rights Coalition*
10. Anna Palmisano, *Marylanders for Patient Rights*
11. Amy Hennen, *Maryland Volunteer Lawyers Service*
12. Tori Nefflen, *Patient Representative*
13. Godlee Davis, *DECO Recovery Management*
14. Leslie Bender, *Clark Hill Law Firm*
15. Neal Karkhanis, *League of Life and Health*
16. Kenneth Krach, *Office of the Commissioner of Financial Regulation*
17. Jedd Bellman, *Office of the Commissioner of Financial Regulation*
18. Megan Renfrew, *HSCRC*
19. Dennis Phelps, *HSCRC*
20. Stan Lustman, *HSCRC*

maryland
health services
cost review commission

Appendix IV: Chapter 770, 2021

See next page

Chapter 770

(House Bill 565)

AN ACT concerning

Health Facilities – Hospitals – Medical Debt Protection

FOR the purpose of specifying the method for calculating family income to be used for certain purposes under a certain hospital financial assistance policy; requiring that the description of a hospital's financial assistance policy that is included on a certain information sheet include a certain section; requiring a hospital to submit annually a certain report to the Health Services Cost Review Commission at a certain time; requiring the Health Services Cost Review Commission to post certain information on its website; altering the required contents of a hospital's policy on the collection of debts owed by patients; ~~requiring a hospital to provide a refund of certain amounts collected from a patient or the guarantor of a patient who was found eligible for reduced–cost care on the date of service; establishing certain prohibitions on hospitals that charge interest fees on hospital bills;~~ prohibiting a hospital from charging interest or fees on certain debts incurred by certain patients; requiring a hospital to provide in writing to certain patients information about the availability of a certain installment payment plan; requiring a hospital to provide certain information to a patient, the patient's family, an authorized representative, or the patient's legal guardian at certain times; ~~prohibiting a certain payment plan from requiring a patient to make certain monthly payments and imposing certain penalties; requiring a hospital to determine certain adjusted monthly income in a certain manner under certain circumstances; requiring a certain payment plan to have a certain repayment period;~~ requiring the Health Services Cost Review Commission to develop certain guidelines, with input from stakeholders, for an income–based payment plan; prohibiting a hospital from seeking legal action against a patient on a debt owed until the hospital has implemented a certain payment plan; establishing that certain patients are deemed to be compliant with a certain payment plan under certain circumstances; requiring a patient to contact the health care facility and identify a certain plan under certain circumstances; authorizing a health care facility to waive certain payments required in a payment plan under certain circumstances; providing that a health care facility may not be required to waive certain payments; requiring a hospital to demonstrate that it attempted in good faith to meet certain requirements and guidelines before the hospital takes certain actions; providing that certain provisions of this Act do not prohibit a hospital from using a certain vendor for a certain purpose; altering and specifying certain time periods during which and the circumstances under which a hospital is prohibited from taking a certain action; prohibiting a hospital from reporting certain information about certain patients to a consumer reporting agency; prohibiting a hospital from taking certain actions against certain patients under certain circumstances; requiring a hospital to provide certain instructions to a consumer reporting agency under certain circumstances; repealing a certain authorization for a hospital to hold a certain lien; prohibiting a hospital from requesting a certain lien

in a certain action; prohibiting a hospital from filing an action or giving a certain notice to a patient for nonpayment of debt until after a certain time period; prohibiting a hospital from taking certain actions if the hospital files a certain action; prohibiting a hospital from requesting a certain writ to garnish certain wages or filing a certain action under certain circumstances; ~~prohibiting a hospital from filing a certain action if a certain debt is below a certain amount;~~ prohibiting a hospital from making a certain claim against an estate of a deceased patient under certain circumstances; authorizing a hospital to offer the family of a certain patient the ability to apply for financial assistance; prohibiting a hospital from filing a certain action ~~against a certain patient or~~ until certain conditions are met; ~~prohibiting a hospital from delegating certain collection activity to a debt collector to collect a certain amount of debt;~~ prohibiting certain individuals from being held liable for a certain debt; authorizing a certain individual to consent to assume a certain liability under certain circumstances; requiring a hospital to send a certain written notice of intent at least a certain period of time before filing a certain action; providing for the manner of delivery, content, and structure of a certain notice of intent; requiring a certain complaint to include a certain affidavit and be accompanied by certain documents; requiring that a hospital require a debt collector to have certain responsibility for meeting certain requirements under certain circumstances; requiring the Health Services Cost Review Commission, on or before a certain date, to compile certain information and prepare a certain ~~annual~~ report; requiring that a certain report be made available to the public in a certain manner and submitted to certain committees of the General Assembly; altering certain references by changing "outside collection agency" to "debt collector"; making conforming changes; requiring the Health Services Cost Review Commission, on or before a certain date and with input from certain stakeholders, to develop certain guidelines; requiring the Health Services Cost Review Commission, on or before a certain date, to report to certain committees of the General Assembly on certain guidelines; requiring the Health Services Cost Review Commission to conduct a certain study on uncompensated care; requiring the Maryland Health Care Commission to examine the feasibility of using the State–designated Health Information Exchange for a certain purpose and to make a certain report to certain committees of the General Assembly on or before a certain date; providing for a delayed effective date; and generally relating to hospital debt collection policies.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–214.1(b)(1)
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214.1(b)(2)(i) and (ii) and (f)(1)(i) and 19–214.2
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–214.1.

(b) (1) The Commission shall require each acute care hospital and each chronic care hospital in the State under the jurisdiction of the Commission to develop a financial assistance policy for providing free and reduced–cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill.

(2) The financial assistance policy shall provide, at a minimum:

(i) Free medically necessary care to patients with family income at or below 200% of the federal poverty level**, CALCULATED AT THE TIME OF SERVICE OR UPDATED, AS APPROPRIATE, TO ACCOUNT FOR ANY CHANGE IN FINANCIAL CIRCUMSTANCES OF THE PATIENT THAT OCCURS WITHIN 240 DAYS AFTER THE INITIAL HOSPITAL BILL IS PROVIDED**;

(ii) Reduced–cost medically necessary care to low–income patients with family income above 200% of the federal poverty level, **CALCULATED AT THE TIME OF SERVICE OR UPDATED, AS APPROPRIATE, TO ACCOUNT FOR ANY CHANGE IN FINANCIAL CIRCUMSTANCES OF THE PATIENT THAT OCCURS WITHIN 240 DAYS AFTER THE INITIAL HOSPITAL BILL IS PROVIDED,** in accordance with the mission and service area of the hospital;

(f) (1) Each hospital shall develop an information sheet that:

(i) Describes the hospital's financial assistance policy **AND INCLUDES A SECTION THAT ALLOWS FOR A PATIENT TO INITIAL THAT THE PATIENT HAS BEEN MADE AWARE OF THE FINANCIAL ASSISTANCE POLICY**;

19–214.2.

(a) **(1)** Each hospital **ANNUALLY** shall submit to the Commission**[**, at**]:**

(I) AT times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients**; AND**

(II) A REPORT INCLUDING:

1. THE TOTAL NUMBER OF PATIENTS BY RACE OR ETHNICITY, GENDER, AND ZIP CODE OF RESIDENCE AGAINST WHOM THE HOSPITAL,

OR A DEBT COLLECTOR USED BY THE HOSPITAL, FILED AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL;

2. THE TOTAL NUMBER OF PATIENTS BY RACE OR ETHNICITY, GENDER, AND ZIP CODE OF RESIDENCE WITH RESPECT TO WHOM THE HOSPITAL HAS AND HAS NOT REPORTED OR CLASSIFIED A BAD DEBT; AND

3. THE TOTAL DOLLAR AMOUNT OF THE ~~COSTS OF~~ CHARGES FOR HOSPITAL SERVICES PROVIDED TO PATIENTS BUT NOT COLLECTED BY THE HOSPITAL FOR PATIENTS COVERED BY INSURANCE, INCLUDING THE OUT–OF–POCKET COSTS FOR PATIENTS COVERED BY INSURANCE, AND PATIENTS WITHOUT INSURANCE.

(2) THE COMMISSION SHALL POST THE INFORMATION SUBMITTED UNDER PARAGRAPH (1) OF THIS SUBSECTION ON ITS WEBSITE.

(b) The policy **SUBMITTED UNDER SUBSECTION (A)(1) OF THIS SECTION** shall:

(1) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(2) Prohibit the hospital from selling any debt;

(3) Prohibit the charging of interest on bills incurred by self–pay patients before a court judgment is obtained;

(4) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(5) PROHIBIT THE HOSPITAL FROM REPORTING TO A CONSUMER REPORTING AGENCY OR FILING A CIVIL ACTION TO COLLECT A DEBT WITHIN 180 DAYS AFTER THE INITIAL BILL IS PROVIDED;

[(5)**] (6)** Describe the hospital's procedures for collecting a debt;

[(6)**] (7)** Describe the circumstances in which the hospital will seek a judgment against a patient;

[(7)**] (8)** In accordance with subsection (c) of this section, provide for a refund of amounts collected from a patient or the guarantor of a patient who was ~~[~~later~~]~~ found to be eligible for free ~~OR REDUCED–COST~~ care **[**on the date of service**]** ~~MORE THAN 240 DAYS AFTER THE FIRST POSTDISCHARGE~~ **WITHIN 240 DAYS AFTER THE INITIAL BILL WAS PROVIDED**;

[(8)**]** **(9)** If the hospital has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who ~~[~~later~~]~~ was found to be eligible for free ~~OR REDUCED–COST~~ care **[**on the date of the service**]** ~~MORE THAN 180 DAYS AFTER THE FIRST POSTDISCHARGE~~ **WITHIN 240 DAYS AFTER THE INITIAL BILL WAS PROVIDED** for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacate the judgment or strike the adverse information; **[**and**]**

[(9)**]** **(10)** Provide a mechanism for a patient to:

(i) Request the hospital to reconsider the denial of free or reduced–cost care; **[**and**]**

(ii) File with the hospital a complaint against the hospital or **[**an outside collection agency**]** **A DEBT COLLECTOR** used by the hospital regarding the handling of the patient's bill**; AND**

(III) ALLOW THE PATIENT AND THE HOSPITAL TO MUTUALLY AGREE TO MODIFY THE TERMS OF A PAYMENT PLAN OFFERED UNDER SUBSECTION (E) OF THIS SECTION OR ENTERED INTO WITH THE PATIENT; AND

(11) PROHIBIT THE HOSPITAL FROM COLLECTING ADDITIONAL FEES IN AN AMOUNT THAT EXCEEDS THE ~~COST OF THE HOSPITAL SERVICE~~ APPROVED CHARGE FOR THE HOSPITAL SERVICE AS ESTABLISHED BY THE COMMISSION FOR WHICH THE MEDICAL DEBT IS OWED ON A BILL FOR A PATIENT WHO IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

(c) (1) Beginning October 1, 2010, a hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2–year period after the date of service, was found to be eligible for free ~~OR REDUCED–COST~~ care on the date of service.

(2) A hospital may reduce the 2–year period under paragraph (1) of this subsection to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free ~~OR REDUCED–COST~~ care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the requested information.

(3) If a patient is enrolled in a means–tested government health care plan that requires the patient to pay out–of–pocket for hospital services, a hospital's refund policy shall provide for a refund that complies with the terms of the patient's plan.

(D) ~~**IF A HOSPITAL CHARGES INTEREST FEES ON A HOSPITAL BILL, THE HOSPITAL MAY NOT:**~~

~~**(1) CHARGE INTEREST IN EXCESS OF AN EFFECTIVE RATE OF SIMPLE INTEREST OF 1.5% PER ANNUM ON THE UNPAID PORTION OF A HOSPITAL BILL;**~~

~~**(2) CHARGE**~~ **A HOSPITAL MAY NOT CHARGE INTEREST OR FEES ON ANY DEBT INCURRED ON OR AFTER THE DATE OF SERVICE BY A PATIENT WHO IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE**~~**; OR**~~

~~**(3) BEGIN ACCRUAL OF INTEREST OR LATE PAYMENT CHARGES UNTIL 180 DAYS AFTER THE DATE OF THE LATER OF:**~~

~~**(I) THE END OF EACH REGULAR BILLING PERIOD; OR**~~

~~**(II) THE PATIENT'S DISCHARGE**~~**.**

(E) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A HOSPITAL SHALL PROVIDE IN WRITING TO EACH PATIENT WHO INCURS MEDICAL DEBT INFORMATION ABOUT THE AVAILABILITY OF AN INSTALLMENT PAYMENT PLAN FOR THE DEBT.

(2) A HOSPITAL SHALL PROVIDE THE INFORMATION UNDER PARAGRAPH (1) OF THIS SUBSECTION TO THE PATIENT, THE PATIENT'S FAMILY, THE PATIENT'S AUTHORIZED REPRESENTATIVE, OR THE PATIENT'S LEGAL GUARDIAN:

(I) BEFORE THE PATIENT IS DISCHARGED;

(II) WITH THE HOSPITAL BILL;

(III) ON REQUEST; AND

(IV) IN EACH WRITTEN COMMUNICATION TO THE PATIENT REGARDING COLLECTION OF HOSPITAL DEBT.

~~**(3) (I) A PAYMENT PLAN OFFERED UNDER THIS SUBSECTION MAY NOT:**~~

~~**1. REQUIRE THE PATIENT TO MAKE MONTHLY PAYMENTS THAT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; OR**~~

~~2. IMPOSE PENALTIES OR FEES FOR PREPAYMENT OR EARLY PAYMENT.~~

~~(II) IF THE PATIENT DOES NOT SUBMIT TAX DOCUMENTATION TO BE USED FOR DETERMINING A PAYMENT PLAN, A HOSPITAL SHALL DETERMINE A PATIENT'S ADJUSTED GROSS MONTHLY INCOME BY FOLLOWING STANDARDS FOR THE DETERMINATION OF INCOME THAT ARE DEVELOPED BY THE COMMISSION IN REGULATIONS.~~

~~(4) A PAYMENT PLAN UNDER THIS SUBSECTION SHALL HAVE A REPAYMENT PERIOD THAT IS NOT LESS THAN THE LONGER OF:~~

~~(I) 36 MONTHS; OR~~

~~(II) A TIME PERIOD THAT WOULD ENSURE THAT PAYMENTS ARE GREATER THAN ACCRUED INTEREST.~~

(3) (I) THE COMMISSION SHALL DEVELOP GUIDELINES, WITH INPUT FROM STAKEHOLDERS, FOR AN INCOME–BASED PAYMENT PLAN OFFERED UNDER THIS SUBSECTION THAT INCLUDES:

1. THE AMOUNT OF MEDICAL DEBT OWED TO THE HOSPITAL;

2. THE DURATION OF THE PAYMENT PLAN BASED ON A PATIENT'S ANNUAL GROSS INCOME;

3. GUIDELINES FOR REQUIRING APPROPRIATE DOCUMENTATION OF INCOME LEVEL;

4. GUIDELINES FOR THE PAYMENT AMOUNT THAT:

A. MAY NOT EXCEED 5% OF THE INDIVIDUAL PATIENT'S FEDERAL OR STATE ADJUSTED GROSS MONTHLY INCOME; AND

B. SHALL CONSIDER FINANCIAL HARDSHIP, AS DEFINED IN § 19–214.1(A) OF THIS SUBTITLE;

5. GUIDELINES FOR:

A. THE DETERMINATION OF POSSIBLE INTEREST PAYMENTS FOR PATIENTS WHO DO NOT QUALIFY FOR FREE OR REDUCED–COST CARE, WHICH MAY NOT BEGIN BEFORE 180 DAYS AFTER THE DUE DATE OF THE FIRST PAYMENT; AND

B. A PROHIBITION ON INTEREST PAYMENTS FOR PATIENTS WHO QUALIFY FOR FREE OR REDUCED–COST CARE;

6. GUIDELINES FOR MODIFICATION OF A PAYMENT PLAN THAT DOES NOT CREATE A GREATER FINANCIAL BURDEN ON THE PATIENT; AND

7. A PROHIBITION ON PENALTIES OR FEES FOR PREPAYMENT OR EARLY PAYMENT.

(II) A HOSPITAL MAY NOT SEEK LEGAL ACTION AGAINST A PATIENT ON A DEBT OWED UNTIL THE HOSPITAL HAS ESTABLISHED AND IMPLEMENTED A PAYMENT PLAN POLICY THAT COMPLIES WITH THE GUIDELINES DEVELOPED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.

~~(5)~~ (4) (I) A PATIENT SHALL BE DEEMED TO BE COMPLIANT WITH A PAYMENT PLAN IF THE PATIENT MAKES AT LEAST 11 SCHEDULED MONTHLY PAYMENTS WITHIN A 12–MONTH PERIOD.

(II) IF A PATIENT MISSES A SCHEDULED MONTHLY PAYMENT, THE PATIENT SHALL CONTACT THE HEALTH CARE FACILITY AND IDENTIFY A PLAN TO MAKE UP THE MISSED PAYMENT WITHIN 1 YEAR AFTER THE DATE OF THE MISSED PAYMENT.

(III) THE HEALTH CARE FACILITY MAY, BUT MAY NOT BE REQUIRED TO, WAIVE ANY ADDITIONAL MISSED PAYMENTS THAT OCCUR WITHIN A 12–MONTH PERIOD AND ALLOW THE PATIENT TO CONTINUE TO PARTICIPATE IN THE INCOME–BASED PAYMENT PLAN AND NOT REFER THE OUTSTANDING BALANCE OWED TO A COLLECTION AGENCY OR FOR LEGAL ACTION.

~~(6)~~ (5) (I) A HOSPITAL SHALL DEMONSTRATE THAT IT ATTEMPTED IN GOOD FAITH TO MEET THE REQUIREMENTS OF THIS SUBSECTION AND THE GUIDELINES DEVELOPED BY THE COMMISSION UNDER PARAGRAPH (3) OF THIS SUBSECTION BEFORE THE HOSPITAL:

~~(I)~~ 1. FILES AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT; OR

~~(II)~~ 2. DELEGATES COLLECTION ACTIVITY TO A DEBT COLLECTOR FOR A DEBT OWED ON A HOSPITAL BILL BY A PATIENT.

(II) SUBPARAGRAPH (I) OF THIS PARAGRAPH DOES NOT PROHIBIT A HOSPITAL FROM USING AN ELIGIBILITY VENDOR TO PROVIDE OUTREACH TO A PATIENT FOR PURPOSES OF ASSISTING THE PATIENT IN QUALIFYING FOR FINANCIAL ASSISTANCE.

[(d)**] (F)** (1) For at least **[**120**] 180** days after ~~[~~issuing an initial patient bill~~]~~ ~~THE FIRST POSTDISCHARGE BILL WAS PROVIDED~~, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment **[**unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill**]**.

(2) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(3) A HOSPITAL MAY NOT REPORT ADVERSE INFORMATION TO A CONSUMER REPORTING AGENCY REGARDING A PATIENT WHO AT THE TIME OF SERVICE WAS UNINSURED OR ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

(4) A HOSPITAL MAY NOT REPORT ADVERSE INFORMATION ABOUT A PATIENT TO A CONSUMER REPORTING AGENCY, COMMENCE A CIVIL ACTION AGAINST A PATIENT FOR NONPAYMENT, OR DELEGATE COLLECTION ACTIVITY TO A DEBT COLLECTOR:

(I) IF THE HOSPITAL WAS ~~INFORMED~~ NOTIFIED IN ACCORDANCE WITH FEDERAL LAW BY THE PATIENT OR THE INSURANCE CARRIER THAT AN APPEAL OR A REVIEW OF A HEALTH INSURANCE DECISION IS PENDING~~, AND UNTIL 60 DAYS AFTER THE APPEAL IS COMPLETE~~ WITHIN THE IMMEDIATELY PRECEDING 60 DAYS; OR

(II) ~~UNTIL 60 DAYS AFTER~~ IF THE HOSPITAL HAS COMPLETED A REQUESTED RECONSIDERATION OF THE DENIAL OF FREE OR REDUCED–COST CARE THAT WAS APPROPRIATELY COMPLETED BY THE PATIENT WITHIN THE IMMEDIATELY PRECEDING 60 DAYS.

(5) IF A HOSPITAL HAS REPORTED ADVERSE INFORMATION ABOUT A PATIENT TO A CONSUMER REPORTING AGENCY, THE HOSPITAL SHALL INSTRUCT THE CONSUMER REPORTING AGENCY TO DELETE THE ADVERSE INFORMATION ABOUT THE PATIENT:

(I) IF THE HOSPITAL WAS INFORMED BY THE PATIENT OR THE INSURANCE CARRIER THAT AN APPEAL OR A REVIEW OF A HEALTH INSURANCE DECISION IS PENDING, AND UNTIL 60 DAYS AFTER THE APPEAL IS COMPLETE; OR

(II) UNTIL 60 DAYS AFTER THE HOSPITAL HAS COMPLETED A REQUESTED RECONSIDERATION OF THE DENIAL OF FREE OR REDUCED–COST CARE.

[(e)**] (G)** (1) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill.

(2) **[**If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt**] A HOSPITAL MAY NOT REQUEST A LIEN AGAINST A PATIENT'S PRIMARY RESIDENCE IN AN ACTION TO COLLECT DEBT OWED ON A HOSPITAL BILL**.

(3) (I) A HOSPITAL MAY NOT FILE AN ACTION AGAINST A PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL OR GIVE NOTICE TO A PATIENT UNDER SUBSECTION (I) OF THIS SECTION UNTIL AFTER 180 DAYS AFTER THE ~~FIRST POSTDISCHARGE~~ INITIAL BILL WAS PROVIDED.

(II) IF A HOSPITAL FILES AN ACTION TO COLLECT THE DEBT OWED ON A HOSPITAL BILL, THE HOSPITAL MAY NOT REQUEST THE ISSUANCE OF OR OTHERWISE KNOWINGLY TAKE ACTION THAT WOULD CAUSE A COURT TO ISSUE:

1. A BODY ATTACHMENT AGAINST A PATIENT; OR

2. AN ARREST WARRANT AGAINST A PATIENT.

(4) A HOSPITAL MAY NOT REQUEST A WRIT OF GARNISHMENT OF WAGES OR FILE AN ACTION THAT WOULD RESULT IN AN ATTACHMENT OF WAGES AGAINST A PATIENT TO COLLECT DEBT OWED ON A HOSPITAL BILL IF THE PATIENT IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

~~**(5) A HOSPITAL MAY NOT FILE AN ACTION AGAINST A PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL IN AN AMOUNT OF $1,000 OR LESS.**~~

~~**(6)**~~ **(5) (I) A HOSPITAL MAY NOT MAKE A CLAIM AGAINST THE ESTATE OF A DECEASED PATIENT TO COLLECT A DEBT OWED ON A HOSPITAL BILL IF THE DECEASED PATIENT WAS KNOWN BY THE HOSPITAL TO BE ELIGIBLE FOR FREE CARE UNDER § 19–214.1 OF THIS SUBTITLE OR IF THE VALUE OF THE ESTATE AFTER TAX OBLIGATIONS ARE FULFILLED IS LESS THAN HALF OF THE DEBT OWED.**

(II) A HOSPITAL MAY OFFER THE FAMILY OF THE DECEASED PATIENT THE ABILITY TO APPLY FOR FINANCIAL ASSISTANCE.

~~(7)~~ (6) A HOSPITAL MAY NOT FILE AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT:

~~(I) WHO WAS UNINSURED AT THE TIME SERVICE WAS PROVIDED; OR~~

~~(II)~~ ~~UNTIL~~ UNTIL THE HOSPITAL DETERMINES WHETHER THE PATIENT IS ELIGIBLE FOR FREE OR REDUCED–COST CARE UNDER § 19–214.1 OF THIS SUBTITLE.

~~(8) A HOSPITAL MAY NOT DELEGATE COLLECTION ACTIVITY TO A DEBT COLLECTOR FOR DEBT OWED ON A HOSPITAL BILL BY A PATIENT THAT IS $1,000 OR LESS.~~

(H) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A SPOUSE OR ANOTHER INDIVIDUAL MAY NOT BE HELD LIABLE FOR THE DEBT OWED ON A HOSPITAL BILL OF AN INDIVIDUAL WHO IS AT LEAST 18 YEARS OLD.

(2) AN INDIVIDUAL MAY VOLUNTARILY CONSENT TO ASSUME LIABILITY FOR THE DEBT OWED ON A HOSPITAL BILL OF ANY OTHER INDIVIDUAL IF THE CONSENT IS:

(I) MADE ON A SEPARATE DOCUMENT SIGNED BY THE INDIVIDUAL;

(II) NOT SOLICITED IN AN EMERGENCY ROOM OR DURING AN EMERGENCY SITUATION; AND

(III) NOT REQUIRED AS A CONDITION OF PROVIDING ANY EMERGENCY OR NONEMERGENCY HEALTH CARE SERVICES.

(I) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, AT LEAST 45 DAYS BEFORE FILING AN ACTION AGAINST A PATIENT TO COLLECT ON THE DEBT OWED ON A HOSPITAL BILL, A HOSPITAL SHALL SEND WRITTEN NOTICE OF THE INTENT TO FILE AN ACTION TO THE PATIENT.

(2) THE NOTICE REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) BE SENT TO THE PATIENT BY CERTIFIED MAIL AND FIRST–CLASS MAIL;

(II) BE IN SIMPLIFIED LANGUAGE ~~AS DETERMINED IN REGULATIONS ADOPTED BY THE COMMISSION~~ AND IN AT LEAST 10 POINT TYPE;

(III) INCLUDE:

1. THE NAME AND TELEPHONE NUMBER OF:

A. THE HOSPITAL;

B. IF APPLICABLE, THE DEBT COLLECTOR; AND

C. AN AGENT OF THE HOSPITAL AUTHORIZED TO MODIFY THE TERMS OF THE PAYMENT PLAN, IF ANY;

2. THE AMOUNT REQUIRED TO CURE THE NONPAYMENT OF DEBT, INCLUDING PAST DUE PAYMENTS, PENALTIES, AND FEES;

3. A STATEMENT RECOMMENDING THAT THE PATIENT SEEK DEBT COUNSELING SERVICES;

4. TELEPHONE NUMBERS AND INTERNET ADDRESSES OF ~~NONPROFIT AND GOVERNMENT RESOURCES, INCLUDING~~ THE HEALTH EDUCATION ADVOCACY UNIT IN THE OFFICE OF THE ATTORNEY GENERAL, AVAILABLE TO ASSIST PATIENTS EXPERIENCING MEDICAL DEBT;

5. AN EXPLANATION OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY; AND

~~6. AN EXPLANATION OF THE STATE MEDICAL DEBT COLLECTION PROCESS AND TIMELINE;~~

~~7. AN EXPLANATION OF THE PATIENT'S RIGHT TO APPEAL TO THE PATIENT'S INSURANCE CARRIER, THE MARYLAND INSURANCE ADMINISTRATION, OR THE HOSPITAL FOR ANY DENIED REIMBURSEMENT OR ACCESS TO FREE OR REDUCED-COST CARE, AND THE NEED TO INFORM THE HOSPITAL IF AN APPEAL IS IN PROCESS; AND~~

~~8.~~ 6. ANY OTHER RELEVANT INFORMATION PRESCRIBED BY THE COMMISSION; AND

(IV) BE PROVIDED IN THE PATIENT'S PREFERRED LANGUAGE OR, IF NO PREFERRED LANGUAGE IS SPECIFIED, EACH LANGUAGE SPOKEN BY A LIMITED ENGLISH PROFICIENT POPULATION THAT CONSTITUTES 5% OF THE

POPULATION WITHIN THE JURISDICTION IN WHICH THE HOSPITAL IS LOCATED AS MEASURED BY THE MOST RECENT FEDERAL CENSUS.

(3) THE NOTICE REQUIRED UNDER THIS SUBSECTION SHALL BE ACCOMPANIED BY:

(I) AN APPLICATION FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, ALONG WITH INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE, AND THE TELEPHONE NUMBER TO CALL TO CONFIRM RECEIPT OF THE APPLICATION;

(II) THE AVAILABILITY OF A PAYMENT PLAN TO SATISFY THE MEDICAL DEBT THAT IS THE SUBJECT OF THE HOSPITAL DEBT COLLECTION ACTION; AND

(III) THE INFORMATION SHEET REQUIRED UNDER § 19–214.1(F) OF THIS SUBTITLE.

(J) A COMPLAINT BY A HOSPITAL IN AN ACTION TO COLLECT A DEBT OWED ON A HOSPITAL BILL BY A PATIENT SHALL:

(1) INCLUDE AN AFFIDAVIT STATING:

(I) THE DATE ON WHICH THE 180–DAY PERIOD REQUIRED UNDER SUBSECTION (G)(3) OF THIS SECTION ELAPSED AND THE NATURE OF THE NONPAYMENT;

(II) THAT A NOTICE OF INTENT TO FILE AN ACTION UNDER SUBSECTION (I) OF THIS SECTION:

1. WAS SENT TO THE PATIENT AND THE DATE ON WHICH THE NOTICE WAS SENT; AND

2. ACCURATELY REFLECTED THE CONTENTS REQUIRED TO BE INCLUDED IN THE NOTICE;

(III) THAT THE HOSPITAL PROVIDED:

1. THE PATIENT WITH A COPY OF THE INFORMATION SHEET ON THE FINANCIAL ASSISTANCE POLICY IN ACCORDANCE WITH SUBSECTION (I)(3)(II) OF THIS SECTION; AND

2. ~~ORAL NOTICE~~ NOTICE OF THE FINANCIAL ASSISTANCE POLICY AS DOCUMENTED UNDER § 19–214.1(F) OF THIS SUBTITLE;

(IV) THAT THE HOSPITAL MADE A DETERMINATION REGARDING WHETHER THE PATIENT IS ELIGIBLE FOR THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY IN ACCORDANCE WITH § 19–214.1 OF THIS SUBTITLE; AND

(V) THAT THE HOSPITAL MADE A GOOD–FAITH EFFORT TO MEET THE REQUIREMENTS OF SUBSECTION (E) OF THIS SECTION; AND

(2) BE ACCOMPANIED BY:

(I) THE ORIGINAL OR A CERTIFIED COPY OF THE HOSPITAL BILL;

(II) A STATEMENT OF THE REMAINING DUE AND PAYABLE DEBT SUPPORTED BY AN AFFIDAVIT OF THE PLAINTIFF, THE HOSPITAL, OR THE AGENT OR ATTORNEY OF THE PLAINTIFF OR HOSPITAL;

(III) A COPY OF THE MOST RECENT HOSPITAL BILL SENT TO THE PATIENT;

(IV) IF THE DEFENDANT IS ELIGIBLE FOR FEDERAL SERVICE MEMBERS CIVIL RELIEF ACT BENEFITS, AN AFFIDAVIT THAT THE HOSPITAL IS IN COMPLIANCE WITH THE ACT;

(V) A COPY OF THE NOTICE OF INTENT TO FILE AN ACTION ON A HOSPITAL BILL; AND

~~**(VI) DOCUMENTATION THAT THE PATIENT HAS ACKNOWLEDGED RECEIPT OF A COPY OF THE INFORMATION REQUIRED TO BE PROVIDED BY THE HOSPITAL UNDER SUBSECTION (I)(3) OF THIS SECTION; AND**~~

~~**(VII) DOCUMENTATION THAT THE HOSPITAL HAS PROVIDED WRITTEN AND ORAL NOTICE OF THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY TO THE PATIENT.**~~

(VI) A COPY OF THE PATIENT'S SIGNED CERTIFIED MAIL ACKNOWLEDGMENT OF RECEIPT OF THE WRITTEN NOTICE OF INTENT TO FILE AN ACTION, IF RECEIVED BY THE HOSPITAL.

[(f)**] (K)** If a hospital delegates collection activity to **[**an outside collection agency**] A DEBT COLLECTOR**, the hospital shall:

(1) Specify the collection activity to be performed by the **[**outside collection agency**]** **DEBT COLLECTOR** through an explicit authorization or contract;

(2) Require the **[**outside collection agency**]** **DEBT COLLECTOR** to abide by the hospital's credit and collection policy;

(3) Specify procedures the **[**outside collection agency**]** **DEBT COLLECTOR** must follow if a patient appears to qualify for financial assistance; and

(4) Require the **[**outside collection agency**]** **DEBT COLLECTOR** to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the **[**outside collection agency**]** **DEBT COLLECTOR** regarding the handling of the patient's bill; **[**and**]**

(ii) Forward the complaint to the hospital if a patient files a complaint with the **[**collection agency**]** **DEBT COLLECTOR; AND**

(III) ALONG WITH THE HOSPITAL, BE JOINTLY AND SEVERALLY RESPONSIBLE FOR MEETING THE REQUIREMENTS OF THIS SECTION.

[(g)**]** **(L)** (1) The board of directors of each hospital shall review and approve the financial assistance and debt collection policies of the hospital at least every 2 years.

(2) A hospital may not alter its financial assistance or debt collection policies without approval by the board of directors.

[(h)**]** **(M)** The Commission shall review each hospital's implementation of and compliance with the hospital's policies and the requirements of this section.

(N) (1) ~~**THE**~~ **ON OR BEFORE FEBRUARY 1 EACH YEAR, BEGINNING IN 2023, THE COMMISSION SHALL** ~~**PREPARE AN ANNUAL MEDICAL DEBT COLLECTION REPORT THAT IS BASED ON SPECIAL AUDIT PROCEDURE REQUIREMENTS FOR HOSPITALS RELATED TO MEDICAL DEBT**~~ **COMPILE THE INFORMATION REQUIRED UNDER SUBSECTION (A) OF THIS SECTION AND PREPARE A MEDICAL DEBT COLLECTION REPORT BASED ON THE COMPILED INFORMATION.**

(2) THE REPORT REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE:

(I) MADE AVAILABLE TO THE PUBLIC FREE OF CHARGE; AND

(II) SUBMITTED TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) On or before January 1, 2022, the Commission shall develop guidelines, with input from stakeholders, for an income–based payment plan offered under this subsection that includes:

(1) the amount of medical debt owed to the hospital;

(2) the duration of the payment plan based on a patient's annual gross income;

(3) guidelines for requiring appropriate documentation of income level;

(4) guidelines for the payment amount, that:

(i) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income; and

(ii) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article;

(5) guidelines for:

(i) the determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 180 days after the due date of the first payment; and

(ii) a prohibition on interest payments for patients who qualify for free or reduced–cost care;

(6) guidelines for modification of a repayment plan that does not create a greater financial burden on the patient; and

(7) a prohibition on penalties or fees for prepayment or early payment.

(b) In developing the payment plan guidelines required under subsection (a) of this section, the Health Services Cost Review Commission shall seek input from stakeholders, including the Maryland Hospital Association, Maryland Insurance Administration, Office of the Attorney General, labor unions that represent the health care sector, a statewide nonprofit consumer rights group; patients' rights organizations, legal service providers who work with patients who have experienced medical debt; and patients who have experienced medical debt.

(c) On or before January 1, 2022, the Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the guidelines required under subsection (a) of this section.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Health Services Cost Review Commission shall study the impact on uncompensated care of:

(1) providing for a refund of amounts collected from patients or guarantors of patients who were later found by the hospital to be eligible for reduced–cost care; and

(2) requiring a hospital to forgive a judgment or strike adverse information if a hospital obtains a judgment against, or reports adverse information to a consumer reporting agency about patients who were later found by the hospital to be eligible for reduced–cost care.

(b) (1) In conducting the study required under subsection (a) of this section, if the Health Services Cost Review Commission determines that additional hospital data is required, the Commission shall notify the hospital of the data that is required.

(2) Not later than 30 days after receiving notification from the Commission under paragraph (1) of this subsection, a hospital shall submit the required data to the Commission.

(c) On or before January 1, 2022, the Health Services Cost Review Commission shall report the findings of the study required under subsection (a) of this section to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.

SECTION 4. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission shall:

(1) examine the feasibility of using the State–designated Health Information Exchange to support the determination of financial status for purposes of determining eligibility for free or reduced–cost care or for an income–based payment plan; and

(2) on or before December 1, 2021, report the findings from the examination required under item (1) of this section to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article.

SECTION ~~2.~~ 5. AND BE IT FURTHER ENACTED, That ~~this Act shall take effect October 1, 2021~~ Sections 2, 3, and 4 of this Act shall take effect June 1, 2021.

SECTION 6. AND BE IT FURTHER ENACTED, That, except as provided in Section 5 of this Act, this Act shall take effect January 1, 2022.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2021.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: April 13, 2022

RE: Hearing and Meeting Schedule

May 11, 2022 To be determined - GoTo Webinar

June 8, 2022 To be determined - GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.